City of Salford

ANNUAL REPORT

OF THE

Medical Officer of Health

FOR THE YEAR

1962

BY

J. L. BURN, M.D., D.Hy., D.P.H.,

MEDICAL OFFICER OF HEALTH

City of Salford

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MEDICAL OFFICER OF HEALTH

CONTENTS

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at 31st December, 1962.

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STAFF

at 31st December, 1962.

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DEPUTY CHIEF PUBLIC HEALTH INSPECTOR.	J. N. MARSHALL, M.R.S.H., M.A.P.H.I., C.S.I.B
CHIEF CLERK	H. THORNLEY, A.C.C.S.
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PSYCHIATRIC SOCIAL WORKER...	C. W. GEDDES, CERT. SOC. STUDIES, A.A.P.S.W., S.R.N., R.F.N., B.T.A.
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HEALTH EDUCATION OFFICER	MRS. E. HUGHES, S.R.N., H.V.
ADMINISTRATIVE ASSISTANT	J. WARRILOW.
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* By arrangement with the Manchester Regional Hospital Board.

STAFF (*continued*)

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	H. Brearley, M.A.P.H.I., C.S.I.B.
	A. D. Moss, M.A.P.H.I., C.S.I.B.
	J. Lee, M.A.P.H.I., C.S.I.B.
Senior Clerks	Miss D. McMillan.
	L. F. Harper, A.R.S.H.
	T. O'Rourke.
	H. Winstanley.
Ambulance Officer	T. Blackburn, F.I.C.A.P.
Manager of Salford House	D. Hazleton.
Mental Welfare Officers	D. Baker, S.R.N., R.N.M.D.
	Miss M. Normanton.
	Mrs. M. L. Godsell.
	Miss P. B. Edwards, Soc. Science Dip.
	R. G. Roy, B.A. (Hons.).
Mental Welfare Officer (Part-time)...	Mrs. N. E. Joynes, M.A. (Hons.), Soc. Science Cert.
Assistant Superintendent of Health Visiting and Nursing Staff	Miss E. Clarke, S.R.N., S.C.M., H.V.Cert., Tutor's Dip.
Centre Superintendents (Health Visiting)...	Miss E. Greenhalgh, S.R.N., S.C.M., H.V.Cert.)
	Mrs. J. Halliwell, R.F.N., S.R.N., S.C.M., H.V.Cert.
	Mrs. E. Millington, S.R.N., S.C.M., H.V.Cert.
Health Visitors with Special Responsibilities	Mrs. D. Appleby, R.S.C.N., S.R.N., S.C.M., H.V.Cert.
	Miss E. Grimshaw, S.R.N., S.C.M., H.V.Cert
	Miss P. Anderson, S.R.N., S.C.M., B.T.A., H.V.Cert.
	Miss J. Parker, R.F.N., S.R.N., S.C.M., H.V.Cert.
	Mrs. J. Thomas, S.R.N., H.V.Cert.
Part-time Chiropodists	B. D. Blank, M.Ch.S.
	Mrs. L. Blank, M.Ch.S.
	F. G. Lawley, M.Ch.S.

3	Educational Psychologists (Part-time) (Mental Health).
1	Remedial Teacher (Part-time) (Mental Health).
14	General Health Visitors.
7	Health Visitors (Part-time).
16	Clinic Nurses (Health Visiting).
15	Nursing Auxiliaries (Health Visiting).
4	Approved District Teachers (Midwives).
3	Premature Baby Nurses.
2	Breast Feeding Sisters.
17	Midwives.
2	Midwives (Part-time).
7	Queen's Nurses.
4	State Registered Nurses (District Nursing).
4	State Registered Nurses (Part-time) (District Nursing).
5	State Enrolled Nurses (District Nursing).
1	State Enrolled Nurse (Part-time) (District Nursing).
3	Nursing Auxiliaries (District Nursing).
3	Nursing Auxiliaries (Part-time) (District Nursing).
5	Matrons of Day Nurseries.
6	Physiotherapists (Part-time).
3	Supervisors of Training Centres (Mental Health).
2	Wardens of Hostels (Mental Health).
1	Assistant Ambulance Officer.

INTRODUCTION

MR. CHAIRMAN, LADIES AND GENTLEMEN.

In presenting my Annual Report for 1962 I wish to record some striking improvements which have taken place in the control of the environment in environmental hygiene. Thanks to the Salford drive for smoke control the air we breathe is clearer and cleaner. This is not a mere opinion, it is fact. The food Salford people eat is safer with the vigilance of your public health inspectors as well as in better preparation and handling, packing, and storage of food.

The housing conditions under which Salford people live have improved. Many hundreds of houses have been kept in a tolerable condition. The finest achievement of the year was the control of those plague spots of life in urban and industrial areas of houses let in lodgings, or as it is officially known " houses in multiple occupation." Your staff were right off the mark at once and 120 establishments housing many hundreds of people have now the decencies and some of the amenities of life for their tenants. All public-spirited citizens will be glad to know of the new powers which operate to the betterment of some hundreds of families who live under deplorable conditions. These premises constituted a running sore in the health of the community—treatment has been thorough. These advances are the stepping stones to further improvement in other aspects of the surroundings and circumstances in which our people live. Vigilance, wisdom, and action will be needed now and in the future to see that the environment of the people helps them to health instead of hindering them as in the past. You will read of some of the efforts made in the reports of the Chief Public Health Inspector (Mr. H. F. Robinson) and the City Analyst (Mr. G. S. Meadows).

We are particularly concerned in a group of babies aged one to six months who may die from respiratory disease. Admittedly, this problem is very difficult as the progress of illness is often sudden. Every mother will want to protect her baby from infection. Visitors who have colds should not be encouraged to hold the baby and still less to kiss it. Another way of preventing unnecessary illness and loss of life is to see that baby is never allowed to become too cold in a room during severe winter weather. Frail babies may suffer from " cold injury." Our grandmothers may have gone too far in over-clothing babies, but with the light materials nowadays this danger is less. With better methods of heating rooms and preventing chilling draughts in bad weather some babies may be saved. An early call to the doctor in the case of a "chesty" baby is advised. Nowadays a doctor can call in, if he so wishes, a consultant in children's diseases to visit baby at home. In any case the advice of the health visitor should be sought much earlier than it is at present.

Much depends on the front line team—the family doctor, midwife, health visitor, district nurse, home help, public health inspector, and mental welfare officer. Few people outside Council members and their staffs realise the day-to-day work in promoting and preserving the health and wellbeing of all members of the community. One never hears about the epidemics which have *never* occurred, thanks to the protection given to the public not only by vaccination and immunisation, but by the thousand and one efforts to control environmental evils which can allow and encourage the spread of infection.

The public seldom hear of the old folk who are in their own homes, perhaps living alone, who need help ; and the problems of the elderly who face increasing difficulties with age and infirmity, in preventing them from falling into a state of malnutrition or neglect, or in alleviating their infirmities which limit their physical, mental, and social health.

Real progress, if on far too small a scale, has been made in liaison with hospital services and the family doctors. It is a special pleasure to record the good spirit of co-operation between the three services. The Ward Sister and the Health Visitor in particular—those key persons in our health services—are finding much more common ground. They are now in more frequent consultation about those people who need special care from both services.

This is the day of preventive medicine, not only for the population as a whole, but also for the individual person. The air is clearing nowadays, not only in regard to smoke, grit and dirt, but also in regard to reduction in cigarette smoking. I am sure that smoking will be recognised as the commonest cause of disease, disability, and disablement in twenty years time. The relentless rise of lung cancer following an increasing consumption of cigarettes over the last forty years is the ominous epidemic of our age. Perhaps the tobacco manufacturers do not realise that their products will cause a million deaths in the present century from lung cancer alone ; nor are the public aware, for many elements have combined to keep a conspiracy of silence.

Possibly an even more serious problem than lung cancer is that of chronic bronchitis and emphysema. If we believe that happiness and the truly good life are aims of our existence, then we might recognise that bronchitis may be a worse affliction than lung cancer. Many bronchitics suffer the fatigue of increasing weariness and the distress of a hacking cough which gets worse as the years roll on. Nor must we forget the relationship with heart disease, or of the psychological consequences when people are so addicted to nicotine that they cannot give it up, strive though they may.

Once again, I am sure that there is every reason to be satisfied with the efforts made by the department during the year, and in concluding this introduction I should like to offer my sincere thanks to you, Mr. Chairman, and members of the Health Committee, for your help and encouragement and to the staff for their efforts and good work during the year.

I am,

Your obedient Servant,

J. L. Burn

Medical Officer of Health.

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143, Regent Road,
Salford, 5, Lancs.
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STATISTICAL SUMMARY—1962

(Based upon figures supplied by Registrar-General)

Area—The City of Salford has a total area of 5,203 acres.

Population—(Registrar-General's Estimate at Mid-year, 1962)	154,000
,, —(Census, 1961)	155,090

Density—The Mean Density of the City is equal to 29·60 persons per acre

Live Births—Legitimate : 1,490 Males ; 1,421 Females ;		2,911
,, ,, —Illegitimate : 148 ,, 140 ,, ...		288
TOTAL		3,199
Live birth rate per 1,000 population		20·77
Still-births : 47 Males ; 34 Females ;		81
Still-birth rate per 1,000 live and still-births		24·70
Total live and still-births		3,280
Infant Deaths (deaths under 1 year) Legitimate 85, Illegitimate 8		93
Infant mortality rate per 1,000 live births—Total		29·07
,, ,, ,, ,, ,, ,, ,, —Legitimate		28·12
,, ,, ,, ,, ,, ,, ,, —Illegitimate		27·78
Neo-Natal mortality rate (deaths under 4 weeks per 1,000 total live births ...		16·88
Early Neo-Natal mortality rate (deaths under 1 week per 1,000 total live births)		15·63
Illegitimate live births per cent. of total live births		9·00
Perinatal mortality rate (still-births plus deaths under one week per 1,000 total births)—		
Still-births ... ... 81 Deaths under one week ... ... 50 } TOTAL, 131		39·94
Maternal deaths (including abortion)		2
Maternal mortality rate per 1,000 live and still-births		0·6
Deaths : 1,155 Males ; 1,139 Females ;		2,294
Annual rate of mortality per 1,000 of the population		14·90

TABLE 1.

SHOWING THE BIRTHS IN THE CITY OF SALFORD, DEATHS OF LEGITIMATE AND ILLEGITIMATE INFANTS UNDER ONE YEAR OLD AND THE PROPORTION OF DEATHS UNDER ONE YEAR OF AGE PER 1,000 BIRTHS DURING THE YEARS 1941 TO 1962.

Years.	Births.			Percentage of Illegitimate Births to Total Births	Deaths under One Year.			Proportion of Deaths under One Year per 1,000 Births.		
	Total.	Legit.	Illegit.		Total.	Legit.	Illegit.	Total.	Legit.	Illegit.
1941	2518	2377	141	5·5	240	215	25	96	90	177
1942	2823	2632	191	6·8	217	203	14	77	77	73
1943	3085	2863	222	7·2	214	203	11	69	71	50
1944	3251	3025	226	7·0	202	182	20	62	63	88
1945	3022	2749	273	9·0	183	168	15	61	61	55
1946	3849	3610	239	6·2	205	180	25	53	50	104
1947	4220	3973	247	5·9	258	240	18	61	60	73
1948	3761	3570	191	5·1	157	147	10	42	41	52
1949	3628	3387	241	6·6	193	181	12	53	53	50
1950	3354	3123	231	6·9	144	128	16	43	41	69
1951	3091	2881	210	6·8	107	103	4	35	36	19
1952	3100	2913	187	6·0	107	89	18	35	31	96
1953	2964	2794	170	5·7	95	83	12	32	30	71
1954	2867	2692	175	6·1	87	79	8	30	30	46
1955	2700	2544	156	5·8	81	75	6	30	29	32
1956	2826	2682	144	5·1	83	80	3	29	30	21
1957	3026	2851	175	5·8	88	84	4	29	29	23
1958	2930	2738	192	6·5	84	78	6	29	28	31
1959	2959	2789	170	5·7	71	67	4	24	24	24
1960	2991	2752	239	8·0	80	73	7	27	27	29
1961	3018	2769	249	8·3	85	79	6	28	29	24
1962	3199	2911	288	9·0	93	85	8	29	29	28

TABLE 2

SHOWING THE BIRTH RATES, RATES OF MORTALITY FROM ALL CAUSES, TUBERCULOSIS OF RESPIRATORY SYSTEM, CANCER, HEART DISEASES, BRONCHITIS AND PNEUMONIA AND THE INFANT MORTALITY RATES DURING THE YEARS 1948 TO 1962.

Years	Population estimated to middle of each year	Rates per 1,000 Population							
		Births	Deaths from						Deaths under one year of age per 1,000 Births.
			All Causes	Tuberculosis of Respiratory System	Cancer	Heart Diseases	Bronchitis	Pneumonia	
Average 5 years	1943-47	**21·44**	**14·49**	**0·87**	**2·05**	**2·86**	**1·98**	**0·77**	**61·29**
1948	178,100	21·12	11·81	0·78	2·16	2·44	1·14	0·48	41·74
1949	178,900	20·28	13·06	0·63	2·00	3·13	1·45	0·71	53·20
1950	177,700	18·87	12·87	0·50	2·31	3·51	1·30	0·46	42·93
1951	176,800	17·48	14·12	0·46	2·15	4·04	1·78	0·50	34·62
1952	176,400	15·57	12·19	0·35	2·12	3·35	1·33	0·59	34·52
Average 5 years		**18·66**	**12·81**	**0·54**	**2·15**	**3·29**	**1·40**	**0·55**	**41·40**
1953	173,900	17·05	12·36	0·29	2·24	3·24	1·59	0·74	32·05
1954	171,500	16·72	11·98	0·23	2·39	3·44	1·19	0·56	30·35
1955	169,300	15·95	12·30	0·22	2·08	3·46	1·33	0·78	30·00
1956	167,400	16·88	12·34	0·20	2·43	3·48	1·46	0·78	29·37
1957	165,300	18·31	12·97	0·19	2·44	3·75	1·37	0·79	28·75
Average 5 years		**16·98**	**12·39**	**0·23**	**2·32**	**3·47**	**1·39**	**0·73**	**30·10**
1958	163,600	17·91	13·20	0·12	2·20	3·70	1·56	0·84	28·67
1959	162,000	18·27	13·01	0·19	2·43	3·78	1·31	0·78	23·99
1960	161,170	18·56	12·67	0·13	2·44	3·60	1·21	0·62	26·75
1961	154,910	19·45	13·96	0·14	2·39	3·74	1·56	0·84	28·16
1962	154,000	20·77	14·90	0·08	2·42	4·23	1.67	0·91	29·07
Average 5 years		**18·99**	**13·55**	**0·13**	**2·37**	**3·81**	**1·46**	**0·79**	**27·33**

TABLE 3

STATEMENT SHOWING NUMBER OF DEATHS IN THE CITY OF SALFORD FROM THE DISEASES SPECIFIED REGISTERED DURING THE YEARS 1932-1962 AND THE RATES PER 100,000 OF THE POPULATION.

(a) Number of Deaths. (b) Rate per 100,000 of the population.

Year	Bronchitis		Cancer (all sites)		Heart Diseases		Pneumonia		Tuberculosis of Resp. system		Total Deaths	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
1932	172	78·1	396	179·8	562	255·1	253	114·9	228	103·5	2920	1325·5
1933	200	92·2	339	156·2	591	272·4	269	124·0	248	116·0	3009	1386·6
1934	133	62·2	400	187·1	637	297·9	243	113·6	201	94·0	2932	1371·1
1935	131	62·4	348	165·7	656	312·4	236	112·4	190	90·5	2734	1301·9
1936	154	74·8	352	170·9	729	353·9	249	120·9	207	100·5	2893	1404·4
1937	141	69·9	390	193·3	779	386·0	245	121·4	178	88·2	2943	1458·4
1938	86	43·1	344	172·5	691	346·5	210	105·3	192	96·3	2611	1309·4
1939	92	46·8	366	186·2	838	426·2	201	102·2	187	95·1	2698	1372·3
1940	535	308·9	342	197·5	754	435·3	221	127·6	195	112·6	3224	1861·4
1941	333	208·5	276	172·8	559	350·0	211	132·1	173	108·3	2743	1717·4
1942	239	155·9	387	219·8	462	301·4	129	84·1	146	95·2	2223	1450·1
1943	330	215·7	345	225·5	445	290·8	147	96·1	148	96·7	2382	1556·9
1944	271	173·9	328	200·5	461	295·9	101	64·8	151	96·9	2271	1457·6
1945	416	264·5	313	199·0	472	300·1	126	80·1	146	92·8	2459	1563·3
1946	289	170·5	326	192·4	444	262·0	127	74·9	122	72·0	2266	1337·1
1947	288	165·5	351	201·6	488	280·3	122	70·1	131	75·3	2312	1328·2
1948	203	114·0	385	216·2	434	243·7	86	48·3	139	78·0	2103	1180·8
1949	260	145·3	358	200·1	560	313·0	127	71·0	113	63·2	2337	1306·3
1950	231	130·0	410	230·7	624	351·2	82	46·2	89	50·1	2288	1287·6
1951	314	177·6	392	221·7	715	404·4	89	50·3	82	46·4	2497	1412·3
1952	235	133·2	374	212·0	591	335·0	104	59·0	61	34·6	2151	1219·4
1953	277	159·3	390	224·3	563	323·7	129	74·2	50	28·8	2149	1235·8
1954	204	119·0	410	239·1	590	344·0	96	56·0	39	22·7	2055	1198·3
1955	226	133·5	352	207·9	585	345·5	132	78·0	38	22·4	2082	1229·8
1956	244	145·8	407	243·1	583	348·3	131	78·3	33	19·7	2065	1233·6
1957	226	136·7	404	244·4	620	375·1	131	79·3	31	18·8	2150	1300·7
1958	255	155·9	359	219·4	611	370·4	137	83·7	20	12·2	2159	1319·7
1959	212	130·9	394	243·2	612	377·8	127	78·4	31	19·1	2107	1300·6
1960	195	121·0	393	243·8	580	359·9	100	62·0	21	13·0	2042	1267·0
1961	242	156·2	370	238·8	579	373·8	130	83·9	21	13·5	2163	1396·0
1962	258	167·5	374	242·9	651	422·5	141	91·6	13	8·4	2294	1489.6

CAUSES OF DEATH — Registrar General's Return of Deaths in the City of Salford during the year 1962

	Males	Females	Total	Under 1 year		1 year and under 5 years		5 years and under 15 years		15 years and under 25 years		25 years and under 45 years		45 years and under 65 years		65 years and under 75 years		75 years and over	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Tuberculosis Respiratory	12	1	13	...	...	..	...	...	...	...	...	2	...	6	1	3	...	1	
,, Other	1	...	1	...	...	...	...	...	...	...	...		...	...	...	1	...	...	...
Syphilitic Disease	3	3	6	...	...	...	...	...	...	...	...	...	1	1	1	1		1	1
Diphtheria	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Whooping Cough	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Meningococcol Infections	1		1	1	...	...	...	...	...	...	...	...	...	...	...	...	...		...
Acute Poliomyelitis	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Measles	1	...	1	...	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...
Other Infective and Parasitic Diseases	3	...	3	1	...	...	...	...	...	...	..	1	...	1	...	...	..	...	...
Malignant Neoplasm Stomach	33	25	58	...	...	...	...	...	..	...	..	1	...	17	5	7	12	8	8
,, ,, Lung Bronchus	96	14	110	...	...	...	...	...	...	...	...	4	1	54	5	32	4	6	4
,, ,, Breast	...	28	28	...	...	...	...	...	...	...	...	...	1	...	16	...	7	...	4
,, ,, Uterus	...	19	19	...	...	...	...	...	...	...	...	...	2	...	10	...	5	...	2
Other Malignant and Lymphatic Neoplasms	72	87	159	...	...	...	...	...	...	...	2	5	4	31	35	19	20	17	26
Leukaemia, Aleukaemia	2	7	9	...	...	...	...	...	2	...	...	1	2	...	1	...	1	1	1
Diabetes	6	8	14	...	...	...	...	...	...	...	...	...	...	4	2	1	3	1	3
Vascular Lesions of Nervous System	112	182	294	...	...	...	...	...	...	...	1	3	3	31	35	34	52	44	91
Coronary Disease, Angina	235	134	369	...	...	...	...	...	...	...	...	14	1	117	26	63	55	41	52
Hypertension with Heart Disease	16	19	35	...	...	...	...	...	...	...	...	1	...	6	3	4	5	5	11
Other Heart Disease	73	174	247	...	...	...	...	...	...	...	...	5	8	16	28	16	34	36	104
Other Circulatory Diseases	28	59	87	...	...	...	...	...	...	...	...	2	1	6	4	12	18	8	36
Influenza	16	21	37	...	...	...	...	...	...	...	...	...	...	7	2	3	6	6	13
Pneumonia	74	67	141	19	7	2	...	...	...	...	1	1	1	14	9	17	9	21	40
Bronchitis	162	96	258	...	1	...	...	...	...	...	...	1	...	63	13	43	42	55	40
Other Respiratory Diseases	12	6	18	...	...	...	...	...	...	...	...	...	1	6	...	5	4	1	1
Ulcer of Stomach, etc.	15	8	23	...	...	...	...	...	...	...	...	...	...	7	5	4	1	4	2
Gastritis, Enteritis and Diarrhoea	7	8	15	4	2	...	...	...	1	...	...	...	...	...	...	2	3	1	2
Nephritis and Nephrosis	4	3	7	...	...	...	...	...	...	...	...	...	...	3	1	...	1	1	1
Hyperplasia of Prostate	5	...	5	...	...	...	...	...	...	...	...	...	...	...	...	2	...	3	...
Pregnancy, Childbirth, Abortion	...	2	2	...	...	...	...	...	...	...	1	...	1	...	...	...	...	...	...
Congenital Malformations	11	13	24	5	9	2	2	...	1	...	...	2	...	2	1	...	...	...	...
Other Diseases	94	121	215	25	18	...	...	4	1	...	...	2	6	15	17	18	18	30	61
Motor Vehicle Accidents	16	7	23	...	...	1	...	2	1	4	...	3	...	5	2	...	2	1	2
All Other Accidents	31	19	50	...	1	3	...	1	2	...	...	2	...	11	2	6	3	8	11
Suicide	14	8	22	...	...	...	...	...	...	...	...	3	1	10	6	1	1	...	...
Homicide and Operations of War	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
TOTALS	1,155	1,139	2,294	55	38	9	2	7	8	4	5	53	34	433	230	294	306	300	516

ENVIRONMENTAL SANITATION

It has been stated that the ideal climatic conditions for the development of Man are in the sub-tropical regions, but due to the prevalence of insect-borne diseases men migrated into cooler regions and populations increased in these areas. Due to the conditions existing shelter, warmth and food became the problems uppermost in the minds of the people, and it is in these spheres that the Public Health Inspector is so vitally concerned.

In connection with housing a complete survey of the City has been made in order to evaluate correctly those properties which are, or should be, in clearance areas, and also to highlight those houses which, although without the basic necessities of hot water, baths, etc., will have to remain for at least the next twenty years. It is hoped that by letter and personal approach the owners of these houses will be persuaded to take advantage of the grant facilities offered to them.

A systematic survey is also proceeding in connection with houses in multi-occupation and the improvement in this type of accommodation is pleasing to see. I am of the opinion that the only way to deal with this problem is to progress street by street, area by area, so that the occupants do not float into other houses in the neighbourhood and aggravate conditions which may already be poor.

In the province of Smoke Control progress is being made according to the programme which should make Salford completely smokeless by 1967. The problems associated with Smoke Control are mainly those in connection with the quality and supply of fuels, and the aversion of people to change.

The control of the food supply to the City has continued both in the inspection of food and the premises in which it is prepared and sold. The result of an investigation into the use of frying pans shows that more attention should be paid by public health officials to the type and quality of equipment used in domestic premises.

Finally, it is with regret that I have to record the death of Mr. J. C. Starkey on the 23rd March, 1962. Mr. Starkey was Chief Public Health Inspector from 1952, having previously been Deputy for eight years. He was noted for his investigations and pronouncements in the field of food hygiene, notably the principle of Temperature Control in relation to food poisoning, and also to methods used in sewer baiting for rodent control.

HOUSING : SLUM CLEARANCE

The year 1962 was an important and productive year in the field of Slum Clearance. Important in that the whole programme for the clearance of unfit houses in Salford was revised and substantially extended, productive in that more than one thousand houses were represented as unfit and the representation programme was adapted to deal with approximately 1,500 houses each year for the next ten years.

It had long been apparent that Salford's original programme, drawn up in 1955, excellent though it had been at the start, no longer presented a true

picture of the extent and complexity of the slum clearance problems of the City. Briefly it was decided after a close and detailed study of the City as a whole that a further 11,500 houses merited inclusion in a long-term programme of clearance. To this was added a balance of approximately 7,000 houses remaining from the original programme, giving a total of 18,500 houses meriting treatment in clearance areas. An integrated, timed schedule was prepared to deal with the bulk of these houses in a ten-year period based on the acquisition of 1,500 houses per year for either immediate demolition within twelve months of acquisition or for selective closure and patch maintenance for properties in deferred demolition areas.

Industrial cities present many problems with their over-large proportions of congested unfit houses and no single method of attacking the problems can ever be satisfactory. In Salford, we are endeavouring to find the most suitable solutions to the problems in the following ways :—

(*a*) the clearance of 50 houses per year on the basis of individual unfitness ;

(*b*) the extension of the clearance programme to acquire 1,500 houses each year ;

(*c*) the planning of substantially sized " improvement " areas where a concerted effort will be made substantially to improve the background amenities of some 250 families each year ;

(*d*) an all-out drive on the problems associated with houses in multiple occupation ;

(*e*) a progressive drive towards the repair of properties by areas.

The present methods being employed will be modified as found necessary as the schemes progress. Slum clearance tactics and methods must remain fluid and adaptable to the changing needs of the City and to the improving standards of life of the people. Where shortage of land is so pronounced as in Salford it is essential that the twin needs of slum clearance and redevelopment are closely linked. We are fortunate that a very active and close liaison between the Corporation departments concerned ensures that at all stages the needs of both are fairly balanced.

Clearance Areas Represented During 1962

Area	Number of dwellinghouses and dwellinghouse/shops
Hightown Clearance Area C.P.O.	537
Ellor Street Nos. 8A, 8B, 8C, 8D and 8E Clearance Areas C.P.O.'s	339
Lower Broughton (Nos. 1 and 2 River) Clearance Area C.P.O. ...	192
TOTAL	1,068

Orders Confirmed During 1962

The following Orders were confirmed during the year by the Minister of Housing and Local Government :—

Order	Number of Dwellings	Type of Order	Subsequent Action
Brindleheath Nos. 1–4 Clearance Areas ...	330	C.P.O. (deferred)	Corporation entry, April, 1962.
Regent Road Nos. 1 and 2 Clearance Areas...	240	C.P.O. (immed.)	Rehousing commenced October, 1962.
Cheetham Clearance Area	169	C.P.O. (deferred)	Corporation entry, August, 1962.
St. Matthias' No. 8 Clearance Area	8	C.P.O. (immed.)	Corporation entry, July, 1962.
TOTAL	747		

Unfit houses demolished or closed during 1962 (including individually unfit houses) :—

	Dwellings	Persons Rehoused
First quarter	108	367
Second ,, ...	125	404
Third ,, ...	79	239
Fourth ,, ...	84	263
ANNUAL TOTAL	396	1,273

Additionally during the year 26 individually unfit properties were either demolished or closed and 124 persons were re-housed by the Corporation.

Re-housing (Removal and Disinfestation)

The Council accept responsibility for the removal of normal household furnishings and effects of families living in clearance areas to the new property. Contracts are let on competitive tender for all except the smallest clearance area and the Council's removal contractor undertakes the removal at a minimum of 24 hours notice. Adequate safeguards under the contractors' insurance schemes cover the authority against claims for loss or damage during removal.

In all cases of tenants being re-housed in Council properties the disinfestation of furniture and effects is carried out by spraying with an approved insecticide with a residual effect. This work is carried out by the Health Committee's own disinfestation service. In every case the fabric of the building is thoroughly disinfested prior to demolition.

Special Treatment in Deferred Demolition Areas

Because of the serious and extensive nature of Salford's slum clearance problem the large-scale use of the powers of retention of properties as provided under Section 48 of the Housing Act, 1957, is practised. Areas treated in this manner are known as " Deferred Demolition " Areas.

A proportion of properties cannot even be made weatherproof at anything like reasonable expense and a well-proven system of selective closure or demolition is carried out together with the patch maintenance of the remaining properties. With the complete co-operation of the Housing Manager and his staff, this system works well. Once a Deferred Demolition Area is confirmed a complete inspection of the properties is carried out to determine those houses which cannot be made tolerable for the time being and those which will benefit from patch maintenance. The Housing Manager is then supplied with a list of properties for which closure or demolition is recommended and a schedule of repairs for the houses which are to remain standing. Once entry on the area is effected the Housing Committee accepts responsibility for the management and maintenance of the houses until they are finally demolished.

Immediate Demolition Areas—Special Problems

As noted in previous reports prolonged periods of inclement weather result in particular hardships for families awaiting re-housing from Immediate Demolition Areas. Normal amenities are lacking in any case and when this condition is aggravated by the effects of bad weather on unfit houses and by the depressing and chaotic background created by the piecemeal demolition or gutting of properties as they become vacant, it is little wonder that complaints become very frequent.

Every reasonable effort is always taken to attempt to minimise the discomfort and nuisance created under these conditions but inevitably some hardship does result.

Inter-departmental Co-operation

Almost all major Corporation departments are actively concerned in some aspect of slum clearance and must at all times be kept informed of future proposals and of progress under existing plans. In Salford this problem has been solved by the formation of a joint Housing Working Party under the Chairmanship of the Council's Senior Solicitor and with representation from all interested departments. This working party considers proposals from the Housing Survey Section of the Public Health Inspectorate and submit their recommendations to a meeting of Chief Officers for their consideration. Major matters involving policy decisions are then submitted to the Joint Health and Housing Committees.

The working party met at very frequent intervals during the past year and were of inva uable help in formulating the new extended Slum Clearance programme.

The Improvement of Properties by Area

As a result of the need to save worthwhile properties from premature decay, joint discussions have taken place between public health inspectors and the City Engineer's building surveyors on the necessity to commence the systematic improvement of houses by area.

It is impossible at this stage to give accurate figures of the numbers of properties in the City which require improvement, but it is estimated that at least 6,000 houses merit detailed survey, and of these probably 5,500 will

merit improvement in one form or other. A detailed pilot survey has been carried out of some 253 houses in Seedley ward in an area which is capable of progressive extension to much larger boundaries.

These houses are structurally sound properties capable of improvement and where improvement is both possible and practical without major structural alteration.

In 119 houses there is no form of fixed bath.
,, 232 ,, ,, ,, an external water closet only.
,, 25 ,, ,, ,, only a cold water supply available.
,, 209 ,, ,, ,, no covered fuel store.
,, 22 ,, overcrowding will result from the conversion of bedroom to bathroom accommodation.
,, 253 ,, there is no properly ventilated foodstore available.

In only 9 out of the 253 properties have adequate improvement works already been carried out to merit no further work.

Full records of ownership, family details of tenancies and details of general and structural repair have been taken. It is estimated that serious disrepair or extensive dampness would appear to be an important factor in about 2½% of the properties—in these instances action under the relevant sections of the Housing Act, 1957, will be instituted by the public health inspectors to bring the properties up to a basic minimum standard before attempting improvement.

The entire scheme for improvement will merit a close and detailed working relationship between the major Corporation departments in order to achieve success.

Houses in Multi-Occupation

The Housing Act, 1961, gives Local Authorities new and greatly strengthened powers to deal with squalid living conditions in houses in multi-occupation or let-in-lodgings.

The new legislation gives an entirely new power to apply a code of management, stronger powers for the provision of additional amenities and a new power to execute work in default and to recover the cost. There is power, also new, to limit the number of persons resident in such houses.

Penalties for offences have been substantially increased and now range from £20 for a first offence to a maximum of £100 and three months imprisonment for subsequent offences.

As the conditions in some of these houses are worse than many of those which have been cleared away by slum clearance, the attack should have an even greater drive and energy than that hitherto given to the slum clearance programme.

The new powers are welcomed as giving an opportunity to deal with a problem which has always caused grave concern and it is therefore proposed to take full advantage as quickly as possible so far as Salford is concerned.

A pilot survey was carried out and a standard formulated to apply in relation to these houses regarding the facilities available to the tenants and the maximum permitted numbers of persons allowed to occupy each of the rooms. These standards are as follows :—

Facilities

Each letting to be provided with suitable and sufficient natural and artificial lighting and adequate means of ventilation.

Each letting to be provided with a deep white sink with cold water main supply, to be situated within the letting.

Each letting to be provided with a gas or electric cooker, having an oven, again to be situated within the letting.

Each letting to have suitable means of space heating or an electric or gas point for the use of a space heating appliance.

There should be provided in accessible positions in the houses and in suitably lighted and ventilated compartments, a sufficient number of water closets to be within the standard of one water closet for each three lettings.

There should be a sufficient number of ashbins in an accessible position to ensure efficient storage of refuse based on the total number of persons permitted to occupy the house.

Overcrowding

The standard to be adopted as follows :—

Type of Accommodation	*Permitted Number*	
Bedsitting room	$2\frac{1}{2}$	
Living room	$1\frac{1}{2}$	$3\frac{1}{2}$
Bedroom	2	
Living room	$1\frac{1}{2}$	$5\frac{1}{2}$
Bedroom	2	
,,	2	
Living room	$1\frac{1}{2}$	$7\frac{1}{2}$
Bedroom	2	
,,	2	
,,	2	

The above standard applies in relation to rooms having a floor area of 110 square feet or more, the standard to be reduced accordingly for rooms of less floor area than this and no room having less than 50 square feet floor area may be used for sleeping accommodation.

Thus armed with standards of facilities to be provided, an overcrowding standard, a strict management code and also the necessary legislation to ensure that these standards were reached and maintained, the survey proceeded.

It has been estimated that there are in the region of 250 houses in multiple occupation in the City and in the past months 76 of these houses have been fully inspected and the appropriate action commenced. A total number of 455 separate lettings have been visited.

The following table will give some idea of the number of houses lacking facilities :—

Number of houses inspected			76	(455	lettings)
Houses with insufficient W.C. accommodation			27		
,, ,, ,,	cooking facilities		26	(79	lettings)
,, ,, ,,	personal washing facilities		32	(108	lettings)
Lettings ,, ,,	space heating appliances		2		
,, ,, ,,	natural lighting		14		
Houses ,, ,,	natural lighting to W.C. compartments		6		
Lettings ,, ,,	artificial lighting		6		
Houses ,, ,,	artificial lighting to common parts of the building		14		
Lettings ,, ,,	ventilation		17		
Houses ,, ,,	ventilation to W.C. compartments		6		
,, ,, ,,	means of escape in case of fire		32		
Number of houses overcrowded			20	(32	lettings)
,, ,, ,,	lacking proper standards of management		59		
,, ,, ,,	requiring no action		0		

In order to remedy the defects mentioned above notices have been served on the owners and persons having control of the premises to carry out the work required.

In all, 54 notices under Section 15 of the Housing Act, 1961, have been served to require the provision of extra facilities. A total of 59 management orders are being sought, 19 of which are now operative. Twelve notices requiring the execution of works to remedy neglect of proper standards of management have been served recently. Seventy-one formal and informal notices under Section 90 of the Housing Act, 1957, have been served informing the owners of the maximum number of persons which are permitted to occupy each of the rooms in each house.

The service of these notices has shown some remarkable results. Probably the most outstanding result is the fact that at least six of the larger houses have been sold by their owners to persons apparently having the means to carry out the requirements of these notices, for example, in four of these houses all works have been satisfactorily completed.

On two occasions the owners of multi-occupied houses objected to the Council's intention to make management orders ; in one the order was made and in the other the owners' undertaking was accepted.

An appeal to the County Court was made by one owner against service of a Section 15 notice on the grounds that the notice was served on the wrong person, that the time allowed for execution of the work was insufficient and that the works required were unnecessary. The Court upheld the notices but extended the time for execution of the work by a further twelve weeks owing to difficulties which has been encountered in the drainage system. The work progressed satisfactorily.

It is estimated that at the present rate of progress the survey of Houses in Multiple Occupation will be completed within the next eighteen months.

DRAINS AND SEWERS

The total number of drain and sewer complaints during the year increased to 2,683. Included in this total are 243 complaints from the Housing Department of drainage defects in properties administered by them.

Most drain blockages are found to be only simple blockages and are removed easily by rodding or plunging and no charge is made by the Corporation for this service. Salford is one of the few places in the country which operate this "free" service. Where blockages cannot be removed by this method notices are served upon the owners to have the drains opened up. The Corporation carried out the necessary work in default of the owners in 32 cases. The most common causes of drain blockages are found to be broken pipes and grease, but occasionally such things as scrubbing brushes, floor cloths, coal and toys are found. Drains exposed are inspected by the Drainage Inspector before being covered up and reinstatement takes place.

The Drainage Inspector and Pests Officer work in close contact during investigation of rat complaints and tracing rat runs which usually lead to a defective drain or sewer.

The exceptionally cold, dry winter brought about numerous complaints of sewer gas which in some cases was found to be coal gas. The sewers become sluggish due to the lack of rain and consequently with poor flow an abnormal amount of sewer gas was present. Most of these complaints came from houses with cellar drains and investigation of these drains usually revealed some defect such as open joints, broken pipes and broken gullies which allowed the sewer gas to escape. It was usually found that when the defective drain was repaired no further complaints were made. The City Engineer carried out flushing of the public sewers and in some cases sewer vent pipes were erected. To differentiate between coal gas and sewer gas is very difficult by smell alone and on one occasion during investigation of a sub-floor cavity the Drainage Inspector and his assistant were overcome. The gas in this case was eventually found to be coming from a leaking gas main in the street.

Numerous complaints of percolations into cellars and basements were investigated and colour tests carried out usually indicated the cause as being a defective drain or sewer. British Railways complained of several percolations into their Docks tunnel and inspections of the tunnel were carried out. This tunnel is approximately half a mile in length and difficulties arose in finding the location of the defect at ground level. One cause was found to be a defective drain at a cinema and another at a public house. Several more percolations have still to be investigated but permission to enter the tunnel must first be obtained and then entry can only be made when accompanied with a representative from British Railways.

Public sewer maintenance is carried out by the City Engineer and close contact with the Highways Surveyor is essential as in some cases the cost of maintenance is recoverable.

When any drainage work is carried out advice and assistance is always available : most contractors co-operate with the Drainage Inspector in this matter. Landlords and Agents usually give priority to drainage work and in most cases only the word of the inspector is necessary to have the work carried out.

RODENT CONTROL

(*a*) Sewer Treatment

The whole of the system of sewers within the City has been dealt with during the year as follows :—

Three thousand, one hundred and thirty-seven manholes in forty-one districts were treated three times during the year.

	Date of Treatment 9/1/62 to 1/5/62 with Warfarin	Date of Treatment 24/5/62 to 7/8/62 with Zinc Phosphide	Date of Treatment 9/10/62 to 14/12/62 with Warfarin
Total number of manholes showing take	98	312	241
Total bait taken	243 ozs.	117 ozs.	707 ozs.

This constant attack on the sewers is now paying dividends as the number of surface complaints received has reduced in the last few years.

The " bag baiting " method is still used in all manholes.

(*b*) Surface Investigations and Treatments

During the year 1,444 complaints were investigated, resulting in 510 premises being treated. In 74 cases the trouble was traced to defective drains and in all cases the drains were either repaired or sealed off. The co-operation that exists between the landlords, contractors and the Rodent Control Section is excellent and in all but three instances the works were carried out on verbal notices followed by confirmation letters.

A further 1,507 premises, mostly shops and factories, were inspected in the course of a survey under the Prevention of Damage by Pests Act and 39 premises were treated for rats and 571 for mice.

A free service is given to occupants of dwellinghouses to exterminate rats but a charge is made to owners or occupiers of business premises on the basis of time and material.

It is hoped to bring a new contract system into operation to maintain treatments at various intervals for all types of business premises in the coming year.

All mice complaints are investigated and pre-packed packets of Warfarin are sold to the occupants at 9d. per box—each box containing sufficient poison for two points.

DISINFESTATION

Another year of disinfestation and preventive insect control gives the following tabular account of work accomplished by two full-time operators.

Both operators are licensed drivers and the staff move from job to job by a light van which recorded 7,771 miles during the twelve months.

Insects Attacked	Number of Operations in 1961	Number of Operations in 1962
Bed Bugs	404	176
Cockroaches	621	576
Wood-boring Beetles	1	2
Earwigs	...	5
Flies	7	12
Golden Spider Beetles	12	5
Wasps	3	6
Fleas	16	9
Ants	3	2
Moths	...	1
Steam Flies	3	8
Lice	11	12
Larder Beetles*	9	13
Total Operations (Primary)	1,090	827

In addition to the 827 treatments for specific infestations, 765 houses and lots of furniture were sprayed with insecticide prior to removal of families to new homes either within the City or in overspill areas.

In the last year there were 13 cases of infestation by the Dermestid beetle in new flats on various sites within the City. After treatments with our current insecticides it was found that the larvæ were resistant to D.D.T., resulting in repeated visits to the flats by the operators. Lindane was introduced with excellent results and after the primary visit no further complaints were received from the tenants.

One thousand seven hundred and ninety-seven tins of cockroach powder were sold at the inquiries counter. This is an increase of 830 tins on last year's sales which tends to show that the policy of educating the public to disinfest their own homes is succeeding.

Disinfection

The following table shows the volume of work carried out by two full-time operators at the Disinfection Station :—

	Beds	*Laundry bags containing bedding or clothing or both*
Infected bedding and clothing	249	136
Verminous bedding and clothing	52	95
Clothing of patients admitted to Ladywell Hospital	—	270
Beds and bedding from Ladywell Hospital	298	541
,, ,, ,, ,, Eccles and Patricroft Hospital	10	268
,, ,, ,, ,, Salford Royal Hospital	12	85
,, ,, ,, ,, Hope Hospital	19	120
,, ,, ,, ,, Stretford Health Department	7	6
,, ,, ,, ,, Port Health Authority	6	12
,, ,, ,, ,, Eccles Housing Department	129	146
Blankets from Ambulance Stations—Salford	—	286
Urmston	—	62
Stretford	—	108
Eccles	—	19
Sterilising apparatus and dressing drums from Ladywell Hospital	—	2,139

In addition to the above steam disinfection the following disinfections were carried out by spraying with formaldehyde.

Salford Royal Hospital	25	cubicles
Dwellinghouses	4	
Ambulances	56	
Ships' Cabins	5	
Hospital Library Books	250	

CLEAN AIR ACT, 1956

Smoke Control Areas

The Clean Air Act, 1956, may be regarded as a legal landmark in the field of prevention of air pollution. The embrace of various forms of air pollution shows the essential spirit of pioneering. Like many other Acts it does not go as far as we would wish in particular directions, but it must be borne in mind that the Act is virtually new ground. The tremendous increase in control over air pollution should be regarded as merely the first step in securing a long overdue clean up of the atmosphere. Not all are convinced of and dedicated to the abatement of pollution, thus making our cities and towns cleaner, brighter and healthier places in which to live. When the provisions of the Act are realised throughout the country, when smoke control becomes converted from planning to reality, that first step will have been taken.

Other forms of pollution will no doubt occur and require attention, forms of pollution which the Act does not at present attempt to control may have responded to experiment, whilst that excluded from the scope of the Act may have been brought within it. The opponents of the Act, those who consider it does not go far enough, and all who have deferred taking action under it should consider whether they are justified in so doing and neglecting a most forward thinking measure designed for the benefit of all.

It is particularly pleasing to record that more smoke control areas and orders have been dealt with during the past two years than in the previous four years since the Act came in force. These orders cover large areas and deal with large numbers of houses and other properties. The rate of progress is fully conforming to and supporting the revised and accelerated programme of smoke control designed to complete Salford's action in respect of smoke control areas by 1967. In a city like Salford consisting of dwellings and industry interspersed this is an undertaking of considerable magnitude.

Some Effects of Smoke Control

During the year the first order covering an area of large size became operative. This is the No. 5 Smoke Control Order which covers the Lancaster Road / Claremont Road part of the City. It was noted, with satisfaction, that when fogs occurred in the City those prevalent in the Smoke Control Area were lighter and whiter than those in other parts of the City not subject to smoke control. This is entirely due to the absence of coal smoke. Many residents have remarked on cleaner homes, hotter fires and rooms and abundant hot water, and for these reasons welcome the new fuels. When the order has been in force for a longer period and when other orders come into force greater benefits will accrue. Painting and buildings will not dirty as quickly and a great boon to the housewife will be ensured by the absence of smuts settling on washing hung out to dry. Mothers putting their babies out in their prams will not return to find the pram and cover and sometimes the baby's face covered with smuts.

The improvement in and effects on health can only be assessed after a lengthy period and it is too early at this stage to comment other than to say that it would appear logical to anticipate reduction in chest and allied complaints.

It was very unfortunate that this large Smoke Control Area should have come into force in the October preceding the worst, coldest and longest winter for over 100 years. Fuel supplies were admirably maintained and assistance in obtaining supplies was given when any case of fuel shortage was brought to the notice of the department. It is the practice to notify all residents when a smoke control area comes into force that the Health Department will give all practicable assistance where any difficulties are encountered in using or obtaining the new fuels, and will explain the techniques of operating the new types of appliances and demonstrate the lighting of coke fires using either an electric igniter, sticks and paper or gas ignition.

Sulphur Emission

Rather more attention and publicity than is justified has been devoted to the problem of sulphur emission. It has been said by a few persons that smoke control areas will increase the sulphur content of the air but actually the reverse is the case. Some people will burn electricity which causes no increase, or gas in which the increase is negligible. Where solid fuel is burnt the weight, used with proper operation so as to give the same comfort standard, should be about 20% less. These factors should account for some 25% less sulphur emission from domestic premises.

The sulphur is present naturally in the fuel and the quantity varies with the type of fuel selected. It is known that the sulphur content of coal and fuels is rising. Oil installations tend to create higher sulphur emissions than coal and, as the heavier oils containing the highest proportion of sulphur are frequently used, the sulphur emission is increased accordingly. There is a tendency in industry to switch from coal as a fuel to oil and in domestic premises to demand higher standards of heating and comfort.

The combination of these factors result in sulphur figures that are not as low as may be desired. It must be remembered that were it not for smoke control there would be an even greater increase in sulphur emission.

The removal of sulphur from fuels has been and is being actively considered, but at the present stage development is rather more experimental than practical. The cost is high and the gain slight. Because, at present, it is not practicable to remove sulphur from fuel this is no reason to delay smoke control. " You are only removing the visible smoke " is the usual cry. Of course this is so, but it is far better to achieve what can be done, than to do nothing because all cannot be done. One could just as easily say " we cannot treat any diseases because we cannot cure all diseases."

The removal of visible domestic smoke is vital because this is the only way in which the smoke pall which hangs over this and other cities can be eliminated.

DISPOSAL OF WASTE MATERIALS AND THE CLEAN AIR ACT

Many of the industrial and commercial concerns accumulate over varying periods of time considerable quantities of waste materials. For the majority a weekly disposal of this rubbish is aimed at and is desirable. The methods adopted for disposal vary ; a few arrange for a private contractor to remove and either tip or burn it. Others arrange for the Corporation Cleansing Department to carry out similar services. A long standing practice of some firms has been to burn the rubbish themselves either in the open or in various kinds of drums or containers. Some have even carried out burning in what purports to be home-made incinerators, whilst several have utilised openings in the base of factory chimneys which are no longer used as such and from which the boiler plant has been removed. A further variation is for an old boiler not used for steam raising to be used solely for burning the rubbish, whilst others have burnt it on the existing boiler plant. This range of methods of rubbish disposal is by no means complete but it does indicate the very wide variety of types of disposal. Many of these methods are very naturally deprecated and vigorous efforts are made to effect more suitable means of disposal.

As a result of these efforts the unsatisfactory methods of rubbish disposal are being eliminated. Burning in the open or in drums is completely unsatisfactory and this and the use of home-made incinerators are being supressed. much depends on the quantity and type of materials to be disposed of and some degree of success has been associated with old boiler plants. Holes in factory chimney bases are unsatisfactory and the bricking up of these is considered necessary to prevent further misuse.

Some forward thinking companies have installed incinerator plant but unfortunately these have not always proved successful, smoke emission and fly ash causing trouble. Burning on existing boilers can, for a variety of reasons, be troublesome and also cause smoke emission.

The most satisfactory method so far has been disposal by the local authority, but there is, of course, a limit to this method. The recent introduction of commercial rubbish disposal may solve many problems for the industrial and business concerns. Not every business desires an incinerator which is relatively expensive, requires staff to operate it and needs a certain amount of space which may be more usefully used in other ways. Further, the incinerator generally must suit the type and quantity of rubbish to be disposed of if smoke, ash and grit emissions are to be avoided ; an incinerator suitable for one type of rubbish is not necessarily suitable for all types.

To burn rubbish on the boiler fires creates obvious difficulties and may interfere with stoker mechanism and reduce steam production. Smoke may be created and if the premises are located within a smoke control area it is apparent that the stoker is not burning the fuel for which it was designed and therefore an offence is committed. Each problem of waste disposal must be dealt with on its merits and the solution tailored to solve that problem.

This may appear to be a somewhat lengthy contribution about a lot of rubbish but it has been written to indicate briefly some of the problems associated with the disposal of industrial and commercial wastes.

FOOD POISONING

Eight individual cases of persons affected with food poisoning organisms were notified during the year. Once again there were no mass outbreaks and I must stress once again the principles of temperature control applied to the preparation and storage of food, which I feel have been instrumental in helping to prevent outbreaks in communal feeding.

The cause of individual cases of food poisoning is often hard to trace, but work is carried out in the field of prevention by control of products likely to convey disease. During the year samples of liquid egg for use in the baking trade were examined and samples from a small processing plant were found to contain salmonella typhi-murium organisms. This egg was being distributed to various bakehouses and could have been responsible for cases of food poisoning. Representations made to the owner of this business resulted in all supplies of this commodity being pasteurised and rendered free from salmonella before distribution to the baking trade.

SAMPLING UNDER THE FOOD AND DRUGS ACT, 1955

During the year 1,032 samples were purchased or taken under the Food and Drugs Act, 1955, for analysis by the City Analyst. The details of samples taken and the results of analyses will be found in the City Analyst's section to this report.

The samples included 750 milk samples taken at various stages of distribution in the City. Apart from samples taken from the retail trade, deliveries to hospitals and canteens are checked, and farmers who deliver milk for processing in the City have their consignments regularly sampled.

Legal proceedings were instituted in respect of a sample of pork sausage for a deficiency in meat content and the manufacturer was convicted but given an absolute discharge on payment of £10 10s. 0d. costs, and a licensee convicted of selling watered rum was also given an absolute discharge.

Apart from routine sampling under the Food and Drugs Act, foodstuffs were examined which had been brought to the attention of the department by members of the public and many of these were submitted to the City Analyst for analysis. In these cases the manufacturers are invited to send representatives to discuss these problems and often the manufacturers' premises are visited to obtain a true picture of factors involved. Legal proceedings were instituted against the manufacturers of a tin of casserole meat, which was found to contain a black mould, and a fine of £20 was imposed.

MILK AND MILK BOTTLES

Seven hundred and forty-four samples of designated milk were taken during the year for examination for keeping quality and correct degree of heat-treatment. The results from these samples proved to be of a high standard and the small number of failures in respect of keeping quality was found to be due to delays in distribution which were subsequently rectified. Milk bottles and churns were also tested to ascertain the degree of sterility prior to filling.

The year saw the advent of the non-returnable container into the retail trade in the City. This was introduced by the major dairy companies and is a step I have advocated for some time due to foreign bodies being found in milk as a result of the misuse of bottles and subsequent failure to detect these in cleaning. However, the glass bottle is still mainly used and once again I would draw attention to the hazards of its misuse. The responsibility of using a bottle which has been misused is that of the dairy company, but the public could help to minimise the risk by rinsing and returning. The majority of consumers do this, but once again the small minority is responsible for all the trouble in this respect.

ICE-CREAM SAMPLING FOR BACTERIOLOGICAL EXAMINATION

Samples of ice-cream were taken from producers in the City and producers outside the City retailing within the City. Visits were made to all manufacturers and advice given on hygiene and methods of sterilisation of equipment. In one case bad results were being obtained from manufacture of a cold mix product and investigation showed this to be due to failure to sterilise the ice-cream scoop. This has now been remedied and good results are now being obtained.

The growth of the soft ice-cream industry has seen the manufacture of this type of ice-cream manufactured in vehicles from pre-packed sterile mixes. The important feature from a public health point of view is the cleaning of the machines after each day's use and the sterilisation of equipment before further use. The possibility of using the previous day's mix must not be overlooked and therefore sampling of this product for bacteriological examination is a safeguard.

DESICCATED COCONUT

One thousand and ninety samples of this product were taken during the year. This sampling was carried out to ascertain whether the product was free from salmonella infection, and the large proportion of these samples were taken after heat-treatment of the imported product had been carried out at a factory premises within this City. The untreated product is heavily contaminated with fæcal coliform organisms and salmonella organisms may be present due to unsatisfactory hygienic conditions under which this article may be produced abroad. Salmonella contamination may be sparse and difficult to detect and because of this samples of the heat-treated product were examined on the basis of contamination with fæcal coliform organisms. Samples of the untreated product invariably produce results showing heavy contamination with this organism and because the thermal death-point of the salmonella organism is approximately the same, this is a useful indicator. A result showing freedom from coliform organisms would indicate that the product is free from salmonella organisms.

In addition to sampling the finished product, regular visits were paid to the plant carrying out the heat-treatment and checks made on recording thermometers and the general handling of the product. The company concerned periodically medically examined staff employed and hygienic precautions are taken to guard against cross-infection. After each heat-treatment run the machine is cleaned and sterilised for the following treatment.

Routine sampling of this product is also carried out from retail shops.

HAZARD OF TINNED-STEEL FRYING PANS

A complaint was received that a person had become ill with gastric disturbance and rash. This person had been using a tinned-steel frying pan for the preparation of meals and had noticed that when bacon was being cooked there was a tendency for the tinning to run and form globules under the fat. The complainant was advised to consult his medical practitioner, who noted his symptoms.

The probability of metal absorption was considered likely and, as a result, the frying pan in question was submitted to the City Analyst, and his report showed absorption of lead into the meals prepared to a far greater extent than the amount that could be ingested daily without producing toxic effects. The analyses of meals cooked in a new pan of the same make produced similar results to the one submitted as the result of the complaint.

For the purposes of comparison tinned-steel frying pans of well-known and reputable brands were purchased and submitted for analysis. Meals cooked in some of these pans showed absorption of lead in spite of the fact that no running of the tinning was observed. The amount of lead absorbed was not as great, but one test meal showed amounts greater than the maximum limit for canned meat and far in excess of the general limit for foodstuffs.

It is important to remember that the results obtained by the City Analyst are in relation to meals prepared by normal heating of pans. Some people would tend to use a much hotter pan and thereby increase the risk of absorbing a higher proportion of lead into the meal. Similarly, the practice of scraping the bottom of frying pans could afford a considerable hazard to health in pans of this type.

The information gained from the tests carried out tends to confirm the probability of risk of lead absorption in all utensils of this type and there is no legislation to deal with this matter.

The Food Standards Committee in 1954 recommended that the sale of domestic cooking equipment lined with lead containing tin or pottery-glaze should be controlled. The recommendation has not been implemented by legislation and it would seem futile to set such stringent standards for food laid down in the Lead in Food Regulations, 1961, and allow the manufacture of this type of equipment, the use of which negatives the value of the Regulations.

The Health Committee referred this matter to the Association of Municipal Corporations with a view to informing the Minister of Health of the hazard involved and also to ascertain whether the Minister for the Board of Trade would consider making regulations controlling the manufacture of this type of equipment.

FOOD HYGIENE

The comprehensive survey of food premises referred to in last year's report is well under way, and the inspection of retail shops as the first stage of the survey is almost complete.

The standards required are somewhat higher than in previous surveys consequent upon new legislation, and this has inevitably involved expense

for many traders, notably for occupiers of many cafes and restaurants. It is gratifying, therefore, to be able to report that the vast majority of traders have co-operated fully, and indeed in many cases standards have been achieved which are higher than required by law.

There is, however, no cause for complacency. A significant number of food businesses in the City are carried on in outworn premises where the practice of hygiene is difficult. In premises such as these any laxity in supervision can and does result in a serious breakdown in hygiene, and it is clear that there is no substitute for regular inspections in such premises. An up-to-date " accelerated visiting list " has been compiled, and all premises on the list are to be visited at frequent intervals.

Many of these outworn and unsatisfactory premises have a deceptively attractive appearance to the public. A close inspection may sometimes reveal, however, that the modern exterior is a facade, and that the preparation and stockrooms are like a relic of a bygone age. In such cases it is clear that the firms concerned have found that hygiene pays where it is seen by the customer, and in extreme cases all available money is spent on frontages, to the complete exclusion of any expenditure on stock and preparation rooms.

The following is a summary of some of the points noted on the survey as they apply to specific types of premises :—

Butchers

There are 173 retail butchers in the City and of these the majority are reasonably well equipped. The main deficiency was found to be in the provision of hand-washing facilities separate from the utensil sink. In approximately 30% of cases it has been necessary to require the provision of a wash-hand basin for this purpose. With regard to premises, the most common problem is undoubtedly floors. A substantial number of premises were found to have bare boards in varying stages of wear, with open joints, and a covering of sawdust. It is possible to achieve good hygiene with such a floor, but it is extremely difficult. The following example which occurred recently will illustrate the dangers which can occur in practice :—

An inspection of a certain butcher's premises revealed a heavy infestation of larder beetles in the shop and preparation rooms. It was apparent that the boarded floor was not being properly cleaned and the joints were full of accumulated grease. The sawdust on the floor was in an unwholesome state and larvæ and pupæ of the larder beetle were present in great numbers. Clearly the sawdust was not being renewed regularly and was in fact used as a substitute for cleaning the floor. An inspection of the refrigerator revealed an even more serious state of affairs. Fresh mice droppings were in evidence on meat actually hanging in the refrigerator. This refrigerator had a worn and rotted wooden floor, and the mice were gaining access through the floor and contaminating the meat at will. The affected meat was, of course, destroyed, and the refrigerator taken out of service until the mice had been eradicated and the floor renewed with concrete.

Bakehouses

Despite the trend towards large multiple bakeries, there are still 53 small independent bakehouses in the City. Many are carried on in premises which are dilapidated and too small for the purpose and constant vigilance is necessary to achieve a good standard of hygiene. There are still some small bakehouses

using ovens fired with solid fuel with the firebox actually in the baking room. This creates obvious cleaning difficulties and for this reason the trend to replace these ovens with electrically operated, gas fired or oil fired ovens is a step forward. A number of such conversions have taken place as a result of the survey, and it is hoped that with persuasion the remainder will be converted in the near future.

Cafes and Restaurants

It is in this field that the greatest problems have been found. This is so because, particularly in the poorer districts, premises are used which are not really suitable for the purpose. Cases exist for instance of cafes serving full meals with seats for 30 or 40 people where the size of the kitchen is no greater than a small domestic scullery. In extreme cases even the original kitchen is converted into a dining room and a makeshift lean-to kitchen constructed in the yard.

The provision of water closet facilities for customers has also caused difficulties due to the layout of premises and the situation of existing closets. Nevertheless, much progress has been made, and in only one case so far have legal proceedings been necessary.

PUBLIC HEALTH ACT, 1936, AND THE FOOD HYGIENE REGULATIONS, 1960

The Public Health Inspectors are at present engaged in the inspection of public houses and to date 94 have been visited.

In the case of all but two of these houses, letters have been, or are being, sent to the breweries requesting that existing defects and offences be remedied under the above legislation.

The works required include such items as :—

1. Hand-washing facilities for the bar staff to be provided in a suitable and convenient place, i.e., where possible behind the bar.
2. Cleansing of walls and ceilings including re-decoration both in public rooms and cellars.
3. Increase of equipment washing facilities in the cellar, i.e., hot water.
4. The provision of an intervening ventilated space or chamber to separate the sanitary accommodation from the actual food rooms, i.e., public rooms.
5. Broken and insanitary cellar floors (food room) to be repaired or renewed.
6. Doors to be placed on the fuel storage cellar to separate completely fuel store from food room and so reduce risk of dust contamination.
7. Additional or an increase of artificial lighting to enable efficient cleansing of rooms.
8. Lay-out of the sanitary accommodation be altered to secure the maximum privacy.
9. Major alterations to entire sanitary accommodation which is considered not reasonably accessible.
10. Renewal of insanitary fitments.
11. General repair.

The advice of the Public Health Inspectors has been offered to all the Brewery Companies and this has resulted in numerous site meetings taking place and the relevant matters discussed.

Most of the works requested have been undertaken, whilst a minor percentage is still the subject of consultation.

SWIMMING BATH WATERS

Three hundred and eighty three samples were taken during the year from the four public swimming baths and from a swimming bath situated in one one of the City schools. Samples are taken for chemical examination and to assess bacteriological purity. Samples were generally satisfactory, but some showed excess chlorine, and the Baths Superintendent is notified as a matter of routine of the results of all samples taken.

Two samples were taken of duckboards used in the bathing cabins for examination in connection with virus research. No positive results were obtained from these samples.

WATER SUPPLY

Water supply is obtained from Manchester Corporation's reservoirs and, in general, has been satisfactory. Eleven samples were taken during the year as a result of complaints ; in the main, these were of discolouration of water due to the presence of excess iron oxide. Representations to the Water Department resulted in these matters being rectified.

HAIRDRESSERS AND BARBERS

The expansion in the number of ladies' hairdressing premises has continued, an additional 19 premises being registered during the course of the year.

All premises are required to comply with the bye-laws made under the provisions of the Salford Corporation Act, 1955, before registration is granted. The principal requirements of the bye-laws relate to standards of cleanliness, interior decoration, water supply, sterilisation of instruments and ventilation of premises.

SHOPS ACT, 1950

A number of complaints were received from individual shopkeepers and from trade organisations about contraventions of the Sunday Trading provisions, and of the general closing laws. All the complaints were dealt with informally, the alleged offenders being interviewed and their co-operation obtained.

There has been considerable friction during the year in the Claremont area of the City, where street traders are prevalent in those parts which are not well provided with shops. The position is that street traders can operate outside the permitted hours for shops, without any restriction whatever, and it is not surprising that extremely strong objections are made from time to time by shopkeepers.

Conditions of employment are also controlled by the Act. A particularly bad case found during the extremely cold winter was a large butcher's shop on a busy main road with a staff of four. The staff were not provided with a staff room, or any facilities for meals, and worst of all there were no space heating arrangements whatsoever. A notice was served and an electric heater was fitted, and table and chairs provided for meals.

TOILETS

In the City there are 21 toilets for men (five of which are staffed) and eight toilets for women (six of which are staffed).

Negotiations are nearly complete for toilet provision at the Oldfield Road / Chapel Street junction and it is expected that building will commence in the coming year.

Investigation is still proceeding for suitable sites in various parts of the City.

STATISTICS

NATURE OF INSPECTIONS

Sanitary Defects	16,006
Sub-lets	600
Common Lodging Houses	29
Seamen's Lodging Houses	3
Caravans	36
Factories with Power	216
Factories without Power	1
Workplaces	2
Outworkers' Premises	8
Shop Act Inspections	256
Schools	16
Cinemas and Theatres	29
Public Conveniences	728
Stables	4
Piggeries	14
Pet Shops	41
Diseases of Animals Act	111
Dairies	393
Food Shops	316
Food Preparing Premises	268
Food Shop Survey	2,574
Food Samples	245
Restaurants and Snack Bars	132
Canteens (Factory and School)	93
Unsound Food	360
Food Stalls and Vehicles	386
Swimming Bath and Drinking Water Samples	292
Infectious Diseases	301
Food Poisoning	39
Smoke Abatement	11,146
Smoke Observations	231
Rodent Control	1,429
Pests Act	331
Noise Abatement	32
Public Houses	255
Disinfestations	1,399
Housing Act Inspections	5,420
Miscellaneous	557
TOTAL	44,299
Calls (No Admittance)	4,688

Unsound Food Condemned

	lbs.
Meat (Canned)	13,298
Fruit (Canned)	3,436
Vegetables (Canned)	1,344
Poultry (Canned)	91
Evaporated Milk (Canned)	116
Soup (Canned)	120
Fish (Canned)	109
Creamed Rice Pudding (Canned)	307
Miscellaneous (Canned)	51
Bacon	175
Margarine	2
Dried Fruit	50
Cheese	24
Sausage	58
Lard	153
Cereals	39
Confectionery	326
Sage	7
Frozen Lambs' Liver	39
Biscuits	112
Dates	28
Flour	210
Butter	2
Sugar (Brown)	112
Semolina	14
Desiccated Coconut	3,900
TOTAL	24,123

Registered Food Premises

The following are the number of food premises by type registered under Section 16 of the Food and Drugs Act and the number of dairies registered under the Milk and Dairies Regulations, 1959 :—

Dairies	5
Butchers' Shops manufacturing sausage and cooked meats	60
Fish and Chips Shops	161
Bottled Milk Shops	773
Ice-Cream Manufacturing Premises—Hot mix	6
Cold ,,	8
Ice-Cream Shops	779
Butchers' Shops	202
Bakehouses	88

In addition it is estimated that there are about 1,500 food shops and other food premises which are not subject to registration.

Results of Milk Samples

Test	Milk	Number Tested	Passed	Failed	Per cent. Failure
Phosphatase	Pasteurised	284	279	5	1·76
,,	T.T. Pasteurised	239	237	2	·83
Turbidity	Sterilised	109	109	...	...
Methylene Blue	Pasteurised	284	257	27	·90
,, ,,	T.T. Pasteurised	239	238	1	·41
,, ,,	T.T.	100	79	21	2·1
T.B. Inoculation	Pasteurised	1	1	...	...
,, ,,	T.T.	2	2	...	...

Ice-cream—Results of Samples

Number of Samples	*Grades*
78	1
7	2
10	3
8	4

List of Samples Taken

Food and Drugs other than Milk	240
Milk for Phosphatase Test	538
Milk for Methylene Blue Test	630
Milk for Fats and Solids-not-Fats, etc.	725
Milk for Turbidity Test	109
Ice-Cream	110
Fertiliser and Feeding Stuffs Act Samples	28
Pharmacy and Poisons Act Samples	17
Water Supply Samples	11
Swimming Bath Water Samples	383
Rag Flock Samples	4
TOTAL	2,795

Complaints and Notices

Complaints Received	9,496
Statutory Notices Issued	2,537
Statutory Notices Abated	2,428
Intimation Notices Issued	1,473
Intimation Notices Abated	1,379

Factories Act, 1937

(1) Inspections for purpose of provision as to health :—

Premises.	No. on Register.	Number of		
		Inspections.	Written notices.	Occupiers prosecuted.
1. Factories in which Sections 1, 2, 3, 4 and 6 are to be enforced by the local authorities	108	...	...	...
2. Factories not included in (1) in which Section 7 is enforced by the Local Authority	985	216	21	...
3. Other premises in which Section 7 is enforced by the Local Authority (excluding outworkers premises)	...	...	...	...
TOTAL	1,093	216	21	...

(2) Cases in which defects were found :—

Particulars.	Number of cases in which defects were found			
	Found.	Remedied.	Referred To H.M. Inspector.	Referred By H.M. Inspector.
Want of cleanliness (S.1)	...	...	...	...
Overcrowding (S.2)	...	...	...	...
Unreasonable temperature (S.3)	...	...	...	...
Inadequate ventilation (S.4)	...	...	...	...
Ineffective drainage of floors (S.6)	...	...	...	...
(*a*) Insufficient	3	...	...	...
(*b*) Unsuitable or defective	18	9	4	7
(*c*) Not separate for sexes	...	...	...	...
Other offences against the Act (not including offences relating to outworkers)	...	...	...	...
TOTAL	21	9	4	7

Outworkers

SECTION 110

Number of outworkers in August list required by Section 110 (1)	130
Nature of work : Making, etc., of wearing apparel	130
,, ,, ,, brass and brass articles	—
Number of cases of default in sending list to Council	—
,, ,, ,, ,, prosecutions for failure to supply list	—

SECTION 111

Number of instances of work in unwholesome premises	—
,, ,, notices served	—
,, ,, prosecutions in respect of outworkers premises	—

CITY ANALYST'S SECTION

SUMMARY OF SAMPLES

Food and Drugs Act samples from the City of Salford	1,032
Fertilisers and Feeding Stuffs Act Samples	28
Swimming Bath Waters	377
Miscellaneous Samples (including Contract Samples from the Central Purchasing Committee)	222
Atmospheric Pollution Tests	1,484
TOTAL	3,143
Samples from the Borough of Eccles	172
Samples from the Borough of Sale	79
Samples from the Borough of Stretford	180
GRAND TOTAL	3,574

FOOD AND DRUGS ACT, 1955

Several new regulations affecting the work of a Public Analyst were made and came into force during the year under review. Perhaps the most important of these being The Preservatives in Food Regulations, 1962, which revoked and re-enacted with amendments existing preservatives regulations. In the new regulations the list of permitted preservatives and of specified foods which may contain those preservatives has been extended. Certain other changes have also been made, for example—specified foods may now contain a mixture of permitted preservatives ; any food is allowed to contain up to five parts per million of formaldehyde derived solely from plastic food containers, etc. ; cheese, clotted cream and any canned food may contain nisin. The Milk and Dairies (Preservatives) Regulations, 1962, prohibit the addition of any preservative, as defined, to milk.

The Emulsifiers and Stabilisers Regulations, 1962, together with the Milk and Dairies (Emulsifiers and Stabilisers) Regulations, 1962, control the use of emulsifiers and stabilisers in foods, following the recommendation of the Food Standards Committee. These regulations prohibit the sale of foods containing any emulsifier or stabiliser other than certain permitted ones ; they prohibit the sale of liquid milk and of flour containing any emulsifier, and allow only two of the permitted ones in bread ; they also control the labelling and advertising of these additives.

The Food Standards (Table Jellies) (Amendment and Revocation) Regulations, 1962, require that as from July, 1963, the existing standards for table jellies shall cease to have effect, provided that in the meantime such standards shall not apply in relation to pre-packed jellies conforming to the Labelling of Food Order.

In addition to the foregoing, several existing regulations have been amended slightly by The Food and Drugs (Legal Proceedings) Regulations, 1962, and the Milk and Dairies (Legal Proceedings) Regulations, 1962.

During the year, reports of the Foods Standards Committee were published on Mineral Oil in Food ; Canned Meat ; Hard, Soft and Cream Cheeses ; and Dried Milk. The Canned Meat report, with its recommended standards for all types of canned meat products and also its draft of possible canned meat regulations, is a particularly welcome one.

Most of the samples submitted for analysis are purchased by the Sampling Officer in the normal manner just as a private purchaser would do ; these are known as informal samples. If, however, any irregularity is revealed in these samples, they are then re-sampled formally by the procedure set out in the Food and Drugs Act, and it is only in respect of the formal samples that legal proceedings could normally be taken under the above Act.

In the following report samples pre-fixed by the letter "A" were taken formally and those by the letter "B" informally.

Table 1 classifies the food and drug samples submitted during the year and also gives the number found to be adulterated or irregular. Out of a total of 1,032 samples, 67 or 6·5% were reported against as being adulterated or otherwise irregular. This is higher than the previous year, but it is a somewhat inflated rate due, to a certain extent, to selective sampling of meat products following the Food Standards Committee report on this subject.

TABLE 1

SAMPLES EXAMINED UNDER THE FOOD AND DRUGS ACT DURING 1962

Samples	Number examined	Number adulterated or irregular
Coffee and Tea	12	1
Confectionery Products	25	2
Cereals	7	2
Dairy Products	24	3
Fish Products	7	Nil
Frozen Confectionery and Ice-Cream	12	Nil
Meat Products	79	18
Milk	671	31
Milk (Channel Islands)	79	1
Miscellaneous (unclassified)	13	1
Oils and Fats	8	Nil
Preserves	14	Nil
Pies and Puddings	9	1
Sauces and Condiments	16	1
Soft Drinks	14	1
Vegetables and Fruits	20	1
Drugs	22	4
TOTAL	1,032	67

Milk

During 1962 a total of 750 milks, comprising 671 ordinary milks and 79 Channel Islands milks, were analysed. Of the 31 ordinary milks reported as adulterated, 13 were deficient in fat and 18 contained small amounts of extraneous water. In each case the vendor was cautioned and at the same time further samples were also taken ; these were all found to be satisfactory. In addition to the 31 adulterated ordinary milks, 24 were deficient in non-fatty solids due to natural causes and no extraneous water was present.

The average composition of the milks analysed (excluding Channel Islands) is given in Table 2, the corresponding figures for the previous five years being given for comparison. The minimum requirements stated in the

table are those fixed by The Sale of Milk Regulations, 1939 ; these are not absolute standards, but if a milk falls below these levels it shall be presumed, until the contrary is proved, that the milk is not genuine by reason of the abstraction of fat or non-fatty solids or the addition thereto of water.

TABLE 2

AVERAGE COMPOSITION OF MILK (EXCLUDING CHANNEL ISLANDS)

	1957	1958	1959	1960	1961	1962	*Minimum requirements.*
Fat %	3·67	3·69	3·53	3·62	3·61	3·57	3·00
Non-fatty Solids %	8·78	8·82	8·63	8·68	8·65	8·68	8·50
Total Solids %	12·45	12·51	12·16	12·30	12·26	12·25	11·50

The standard of composition for Channel Islands milk is fixed by the presumptive standards of quality which apply to all milks, and also by The Milk and Dairies (Channel Islands and South Devon Milk) Regulations, 1956, which stipulate an absolute standard of 4·0% for fat in the milk. Of the 79 milks analysed in this class only one was adulterated ; this was an informal sample that contained extraneous water, but on repeat sampling the milk was satisfactory.

Unsatisfactory Food and Drug Samples (other than Milk)

These numbered 35 (or 12·4%) out of a total of 282 examined. Details of the nature of adulteration or irregularity and also the actions taken are given in Table 3.

TABLE 3

UNSATISFACTORY FOOD AND DRUG SAMPLES (OTHER THAN MILK)

Serial Number	Description	Nature of adulteration or irregularity	Remarks
B7760	Sugar	Contained 13% Epsom Salts.	Referred to neighbouring Authority for further action as the article had been purchased there.
B7787	Pork Sausage	17% deficient in meat. Contained undeclared sulphite preservative.	Butcher cautioned.
B7827	Coffee and Chicory Essence.	Deficient in caffeine ...	Manufacturer advised.
B7928	Pork Sausage	Contained undeclared sulphite preservative.	Butcher cautioned.
B54	Orange Drink	Contained excess sulphite preservative.	Manufacturer notified.
B170	Buttered Barm Cakes.	Spread with margarine and not butter.	Vendor given severe warning.
B244	Beef Sausage	25% deficient in meat.	Vendor notified. Further sample satisfactory.
B283	Pork Sausage	22% deficient in meat.	Formal sample A1250 taken.
B286	Soft Cheese	Inadequately described.	Manufacturer advised.
A1250	Pork Sausage	21·5% deficient in meat.	Legal proceedings instituted. Defendant found guilty but given an absolute discharge on payment of 10 guineas costs.

TABLE 3 (*continued*)

UNSATISFACTORY FOOD AND DRUG SAMPLES (OTHER THAN MILK)

Serial Number	Description	Nature of adulteration or irregularity	Remarks
B336	Pork Sausage	Deficient in meat	From the same source as A1250.
B425	Double Cream	Unduly acidic	Vendor notified. Further sample satisfactory.
B350	Sour Cream	Contained only 9% of fat.	Description changed to one not including the word cream.
B544	Plain Flour	Contained a slight excess of prepared chalk.	Further samples taken.
B545	Plain Flour	Contained a slight excess of prepared chalk.	Further samples taken.
B582	Beef Sausage	Proportion of fat to lean meat too high.	Butcher interviewed.
B632	Tincture of Iodine ...	Contained an excess of iodine and potassium iodide.	Manufacturers notified.
B633	Seidlitz Powder	Incorrect label	Packers informed.
B638	Sal Volatile	Deficient in ammonia ...	Found to be old stock. Remainder withdrawn from sale.
B639	Sal Volatile	Deficient in ammonia ...	Found to be old stock. Remainder withdrawn from sale.
B651	Mustard Piccalilli ...	List of ingredients in wrong order.	Packer notified and agreed to amend ingredients.
B659	Currants	Contained an excess of sandy matter.	Packer notified.
B661	Canned Sago Pudding.	Insufficiently cooked during processing.	Producers interviewed and cautioned.
B752	Pork Sausage	Proportion of fat to lean meat too high.	Butcher notified.
B781	All-meat Steakettes ...	This description not justified as a small amount of cereal filler was present.	Description amended.
A1260	Rum	Contained 5·1% excess water.	Legal proceedings instituted. Defendant found guilty but given an absolute discharge on payment of four shillings costs.
B309	Stewed Steak in Gravy.	No legal standards for these products but all were deficient in meat compared with the recommended standards.	Manufacturers or importers notified in most cases.
B456	Stewed Steak with Gravy		
B522	Casserole Beef Steak ...		
B523	Casserole Stewed Steak		
B574	Casserole of Meat ...		
B575	Casserole Beef Steak with Gravy		
B584	Casserole Steak		
B600	Casserole Meat with Gravy		
B601	Stewed Steak with Gravy		

Fertilisers and Feeding Stuffs Act

Twenty-eight samples were examined for compliance with the appropriate regulations made under the above Act. Sixteen of the feeding stuffs were satisfactory, five deficient in protein, and two had an excess and one a deficiency of oil. One fertiliser had an excess of phosphoric acid and one a deficiency ; the remaining two were satisfactory.

All the samples were taken informally and, as the deviations outside the limits of variation were only slight, the action taken with these unsatisfactory samples was to inform the manufacturers accordingly.

Swimming Bath Waters

Water from the various swimming baths in the City is tested regularly to check that an effective level of chlorination is being maintained. The standards adopted are those recommended in the Ministry of Health report on The Purification of the Water of Swimming Baths.

Three hundred and seventy-seven samples were submitted during the year ; of these, 58 contained chlorine somewhat in excess of the level necessary to maintain health safeguards and 17 contained insufficient chlorine to give an adequate safety margin.

Miscellaneous Samples

Included in this group are the contract samples submitted by the Central Purchasing Committee. These numbered 168 out of the total of 222 and consisted of articles such as cleaning materials, polishes, detergents, and various foodstuffs. The samples are examined to see that they conform to specifications which have been made out by the City Analyst, thus ensuring that satisfactory products are obtained at competitive prices.

The remaining 54 samples were submitted by other departments or by private purchasers and were usually concerned with food spoilage or contamination. Table 4 gives details of the more interesting samples in this category.

TABLE 4

DETAILS OF CERTAIN MISCELLANEOUS SAMPLES

Sample	Comment
Apple pie with cream	Infected with mould.
Cream cake contaminated with dark pellets.	The pellets consisted of scorched cake crumbs and were not rodent pellets.
Desiccated coconut	Infested with the rust-red flour beetle.
Blackcurrant drink	Mould growth present.
Butter	Contaminated with dark grey patch caused by mould.
Boiled pork ribs	Became coloured a vivid purple on boiling, probably due to a piece of indelible pencil being present.
Pickles	White sediment present due to bacteria.
Foreign matter from canned meat	Found to be portions of ox skin with adherent hair.
Canned rice pudding	Contained particles of solder.
Canned casserole meat	Contained two relatively large pieces of meat which had been heavily contaminated with mould before entering the can.
Cereal mixture	Infested with grain weevils.
Porridge oats	Extensively infected with mould growths.
Tinned steel frying pan	See separate note.

The tinned steel frying pan referred to in Table 4 was submitted by a private purchaser who had been suffering from symptoms resembling those of lead poisoning, and it was thought that food cooked in the pan may have been responsible for these symptoms.

The tinning on this pan and also on several others purchased for comparison was examined for lead content. It was found that out of the total of six pans examined, the tinning on four contained a high proportion of lead, the other two were satisfactory and contained negligible amounts of lead. In addition, meals cooked in pans having lead in the tinning showed that lead was taken up by the meals to an extent that could present a danger to health.

As there appears to be no legislation in force to control the purity of the tin used for this purpose, representations have been made, through the appropriate channels, to the Ministries concerned asking for its implementation.

Atmospheric Pollution

The laboratory is responsible for making daily atmospheric pollution measurements at five stations situated in different parts of the City. The apparatus used is the one recommended for daily measurements of smoke and sulphur dioxide by the Department of Scientific and Industrial Research, and all the results are used by them in the National Survey of Atmospheric Pollution.

Daily visits have normally to be made to each station to renew the smoke filter and sulphur dioxide absorbent. However, by modifying the apparatus and incorporating a special valve, it is possible to make an automatic daily change and each station need only be visited once each week. It also enables individual daily readings to be made during holidays and week-ends, thus giving more detailed atmospheric pollution data. During the latter part of the year a modified apparatus of this type has been given a trial run at one of the stations and has proved so satisfactory in use that it is hoped during 1963 similarly to modify the apparatus at the other stations.

In collaboration with the Department of Scientific and Industrial Research, the laboratory has also been carrying out an investigation into differing sizes of smoke filters.

Tables 5 and 6 show the average daily concentrations of smoke and sulphur dioxide in the atmosphere at the various sites for each month of the year. If the overall mean of the five stations is compared with that for the previous year, it is seen that, whereas the sulphur dioxide pollution is very similar, there has been a definite reduction in smoke pollution.

TABLE 5

SMOKE POLLUTION

Results expressed as micrograms per cubic metre of air.

Month	Site				
	Regent Road	Cleveland House	Police Street	Murray Street	Encombe Place
1962					
January	825	525	696	624	575
February	408	216	444	342	304
March	752	485	530	507	460
April	428	201	348	245	231
May	402	167	262	189	182
June	304	128	199	150	138
July	257	105	185	142	127
August	298	97	190	119	115
September	382	193	278	210	209
October	543	388	439	385	343
November	696	495	621	497	552
December	850	596	715	590	731
Mean daily reading over all the year	512	300	408	333	331

Overall mean = 377.
Overall mean for 1961 = 402.

TABLE 6

SULPHUR DIOXIDE POLLUTION

Results expressed as micrograms per cubic metre of air.

Month	Site				
	Regent Road	Cleveland House	Police Street	Murray Street	Encombe Place
1962					
January	659	171	463	497	536
February	443	104	294	264	313
March	546	251	524	411	515
April	395	144	336	243	299
May	356	228	285	225	269
June	268	160	197	150	192
July	209	122	178	140	207
August	248	112	187	137	188
September	322	181	258	194	238
October	440	238	393	313	381
November	618	234	556	456	487
December	765	377	735	566	643
Mean daily figure over all the year	439	193	367	300	356

Overall mean = 331.
Overall mean for 1961 = 328.

Certain polycyclic hydrocarbons which possess carcinogenic properties are present in smoke, and each month the smoke stains from Regent Road or Police Street have been examined for these constituents. The results are recorded in Table 7, the hydrocarbons being expressed as micrograms per 100 cubic metres of air and also as parts per million (p.p.m.) of the smoke content of the atmosphere.

TABLE 7

CARCINOGENIC HYDROCARBONS IN THE ATMOSPHERE

Month	Micrograms smoke per 100 cubic metres	Micrograms Hydrocarbon per 100 cubic metres			Parts per Million Hydrocarbons in smoke		
		Pyrene	Coronene	3·4 Benzpyrene plus 1·12 Benzperylene	Pyrene	Coronene	3·4 Benzpyrene plus 1·12 Benzperylene
1962							
January	77,200	7·8	2·7	22·9	101	36	297
February	40,850	0·8	1·7	22·3	18	42	548
March	75,200	1·3	0·7	11·7	17	10	155
April	42,880	1·3	0·7	8·1	31	16	258
May	40,280	Nil	Nil	2·7	Nil	Nil	67
June	30,400	0·2	Nil	5·7	6	Nil	186
July	25,700	0·9	Nil	1·5	35	Nil	57
August	19,000	Nil	0·2	4·9	Nil	8	249
September	27,800	0·5	0·8	8·6	17	30	309
October	49,300	1·0	1·9	13·4	20	39	272
November	69,600	3·3	1·2	31·8	47	18	455
December	71,500	0·9	5·4	38·4	12	76	537

Samples from Neighbouring Authorities

The City Analyst also acts as Public Analyst for the Boroughs of Eccles, Sale and Stretford. During the year the following samples were examined for these Boroughs :—

Eccles : 143 Food and Drug samples and 29 swimming bath waters.

Sale : 77 Food and Drug samples and 2 miscellaneous samples.

Stretford : 180 Food and Drug samples.

Fees totalling £1,043 10s. 0d. have been received by the City Treasurer in respect of this work.

STATUTORY SUPERVISION OF MIDWIVES

(Midwives Act, 1951)

Notification of Intention to Practise

In accordance with the provisions of the above Act, the number of midwives who notified their intention to practise in the area was as follows :—

(*a*) Institutional	49
(*b*) Domiciliary	30
TOTAL	79

Compulsory Post-Graduate Courses

In accordance with the rules of the Central Midwives Board, midwives have continued to attend, at least once in every five years, courses arranged for post-graduate instruction.

ATTENDANCE BY SALFORD MIDWIVES, 1962 :

(*a*) Institutional	6
(*b*) Domiciliary	6
(*c*) Supervisors	1

MISCELLANEOUS NOTIFICATIONS (as required by the rules of the Central Midwives Board)

Notification	Domiciliary	Private Practice	Total
Stillbirth	8	0	8
Death of mother or baby	3 (baby)	0	3
Laying out of dead body...	6	0	6
Infection	38	0	38
Medical aid	845	0	845

DOMICILIARY MIDWIFERY SERVICE

The deputy supervisor, Miss E. Brooks, left the service at the beginning of the year, and Miss M. E. Hodgson, a member of the teaching staff at Jutland House for eleven years, was appointed to this post.

Two main progressive changes have been initiated and established during this year :—

(1) Appointments System—Ante-Natal Clinics

Attendances at clinics had continued to grow in size year by year, resulting in most mothers arriving well before the session was due to commence in their anxiety to be seen first—of necessity, many of these mothers had a day wait before it was possible for them to see the Doctor or Midwife. Mothercraft talks which were attempted during this waiting period were of doubtful value as many young children accompanied their mothers, making talks or films difficult to follow and, in addition, mothers found concentration difficult lest they missed their turn for examination.

The Langworthy area was chosen for a pioneer period at which the appointment system might be tried. First, because this is one of the well-attended clinics at which sessions had been late finishing, and secondly, because the midwife responsible for the clinic had been seconded to the Midwife-Teacher Training College for six months and had had the opportunity of observing the appointments system in many of the clinics in the South of England.

The experiment proved successful—the mothers appreciated very much the more definite time for attending and the tremendous reduction in the waiting period. Doctor and Midwife were able to give more time and thought to each mother and in much quieter surroundings. The advantages to everyone were so definite that it was decided to extend this to all clinics—and this extension was greatly helped by the provision of clerical staff at the midwives clinics, and the clerk is now responsible for discussing with the mother the most suitable time and the actual making of the appointment.

(2) Parentcraft

The aim this year has been to bring together small groups of mothers and fathers-to-be to help them to understand their pregnancy and labour—to guide them in their preparations for their baby and, by discussions and questions, to help them to help each other. The fathers especially enjoy active participation in the practical demonstrations and several have made their own draught-proof cots for the first few weeks after baby's birth.

The initiation of each group is helped very considerably by a film which has been produced especially to help them. The film, " To Janet a Son," was a gift made to the Royal College of Midwives on the occasion of their 80th anniversary. It shows the complete story of a pregnancy and birth of the baby in the most natural way possible, and the whole story is seen through the eyes of Janet, a mother awaiting the arrival of her second baby.

As the months pass, Janet attends discussions, demonstrations and relaxation classes, and a brilliant piece of animation shows the development of the foetus and the muscular activity of the uterus.

The film is a remarkable achievement in that it can be shown to any kind of audience without the slightest risk of offence.

Farley's Infant Food Ltd., who presented the film to the College, have concerned themselves not only with the making of the film but are also ensuring its distribution.

Staff Position

	Establishment	*Staff* (31*st December*) 1962	1961	1960
Supervisor and Tutor	1	1	1	1
Assistant Supervisor	1	1	1	1
Approved District Teachers	5	4	3	5
Midwives	20	17	14	13
Part-time Midwives	—	2	4	—
Breast Feeding Sisters	2	2	2	2
Premature Baby Nurses	3	3	3	3

Statistics

(1) Clinics

(*a*) Attendances :

Statistics relating to ante-natal clinic attendances will be found under "Care of Mothers and Young Children."

(*b*) Bookings :

Total number of domiciliary bookings	1,692	(1,649)
Total number of cancellations (including removals, transfers to hospital, etc.)	446	(337)

(2) Home Visiting

(*a*) Follow-up of clinic defaulters	10,604	(8,562)
(*b*) Routine home visits		
(*c*) Investigations of home conditions :		
Actual homes	478	(264)
Number of visits	1,760	(2,146)

Comparative Statistics—Home Investigations

Year	1962	1961	1960	1959	1958
Totals	478	264	247	222	202

Births

(1) Statistics

Doctor booked and present at delivery	195	(112)
,, ,, ,, not present at delivery	1,131	(1,119)
,, not booked and present at delivery	10	(2)
,, ,, ,, ,, not present at delivery	8	(8)
Total	1,344	(1,203)

N.B.—(*a*) Five cases of twins occurred, making total number of births 1,349
(*b*) Average number of cases per midwife 75
(*c*) Domiciliary births formed (of total Salford births) 52%

Comparative Statistics

Year	Live Births	Stillbirths	Total
1958	1,248	9	1,257
1959	1,181	12	1,193
1960	1,197	10	1,207
1961	1,241	7	1,248
1962	1,341	8	1,349

Number of nursing visits following delivery	23,174	
,, ,, ,, ,, for hospital discharge	2,810	(2,480)
Total	25,984	

(2) Analgesia

	Number of Mothers.	
Nitrous oxide	4	
Trilene	1,037	
Pethidine	908	
Total inhalation analgesia	1,041	*i.e.*, 77·4% of all births

(3) Stillbirths

Comparative Statistics (domiciliary only)	Number of Stillbirths	Rate per 1,000 Registered Births
1958	9	7·15
1959	12	10·0
1960	10	8·3
1961	7	5·83
1962	8	6·0

SUMMARY OF CASES

Classification		Presentation	Weight	Gestation	Condition	Contributory Factors
Ante-partum Anoxia.	1	Breech	lbs. ozs. 4 8	36 weeks	Fresh	Ante-partum hæmorrhage, prematurity, fœtal heart failed during second stage.
	2	—	5 0	47 weeks	Macerated	Cessation of fœtal movements one week before onset of labour. No-one present at birth. No drugs or maternal illness.)
Intra-partum Anoxia.	1	Vertex	5 12	39 weeks	Fresh	Prolapsed cord.
	2	Vertex	6 0	39 weeks	Fresh	Fœtal heart heard until onset of labour — cord round neck, Oligohydramnios, ? neurotic vomiting throughout pregnancy.
	3	Breech	5 0	40 weeks	Fresh	Twin pregnancy—mother refused to go into hospital. Intra-partum hæmorrhage.
	4	Vertex	8 0	40 weeks	Fresh	Cord tightly round neck, obstructed shoulders.
	5	—	6 0	42 weeks by Amenorrhœa	Fresh	Rapid labour—no-one present at birth. Inquest: Atelectasis ; ? Prematurity.
Fœtal Abnormalities.	1	Vertex	5 0	40 weeks	Macerated	Intra-uterine death two days before onset of labour. Hydrocephalus. Micrognathia.

(4) **Neo-Natal Mortality** (born and died at home)

Prematurity	0
Intra-uterine Pneumonia	1
Cerebral Hæmorrhage	1
Asphyxia Neonatorum	1
Cerebral Injury plus Sonne Dysentery	1
TOTAL	4

Four babies born at home were admitted to hospital and subsequently died during the first 28 days of life :—

Congenital Heart	2
Hirshprings Disease plus Prematurity	1
Broncho-pneumonia	1
TOTAL	4

(5) **Emergency Obstetrical Unit**

The Emergency Obstetrical Unit, operating from Hope Hospital, was called out on 20 occasions during the year.

SUMMARY OF CAUSES

Post-partum Hæmorrhage	Fourteen times—twelve of these mothers were subsequently admitted to hospital.
Ante-partum Hæmorrhage	Four times—all mothers were admitted to hospital.
Abnormal presentation of fœtus in labour	Twice—both mothers admitted to hospital.

Puerperium

Infection—Statutory notifications received :—

	Hospital	District	Total
Puerperal Pyrexia	31	1	32
Ophthalmia Neonatorum	1	—	1
Pemphigus ,,	—	—	—

Causes of Pyrexia were as follows :—

	Hospital	District	Total
Uterine Infection	8	—	8
Respiratory Infection	8	—	8
Urinary Infection	6	—	6
Breast Infection	1	1	2
Sonne Dysentery	1	—	1
Undiagnosed	7	—	7

Ophthalmia Neonatorum : One case only was notified during the year and this was non-gonococcal in origin.

Breast Feeding Service

During the past year many mothers have made contact with the breast feeding service through recommendation from their friends, others being referred by Midwives, General Practitioners, Hospitals and Health Visitors.

One particularly interesting case this year was a mother who had successfully breast-fed four previous babies. This, the fifth baby, vomited each time it had a complement of dried milk. On visiting it was found that the baby appeared to have all the signs and symptoms of pyloric stenosis. The General Practitioner was consulted and the baby referred to Dr. Mackay.

After investigation it was found that the baby had an allergy to cow's milk—early diagnosis had prevented the baby from having a great weight loss. Breast feeding was continued with a complement of goat's milk and progress is satisfactory, although the allergy still persists.

Great interest was shown in the Salford Breast Feeding Service at a recent midwives refresher course in Hull and our representative there was able to help with many practical suggestions at the discussions.

RESULTS OF DISCHARGED MOTHERS

Wholly breast-fed	71
Breast with complement	38
Artificially fed	89
TOTAL	198

Number of home visits paid	1,667
,, ,, "no access" calls	72
TOTAL	1,739
Total number of clinics attended	219

Domiciliary Premature Baby Service

Small and premature babies have a much greater chance of survival due to the very skilled care which is given by the members of this staff. It is notable that in spite of the atrocious housing conditions of many of these homes and the severely cold winter no babies under the care of this service died in the neo-natal period.

STATISTICS. Number of premature infants under care :—

Premature infants born at home	54
Babies referred from hospitals	26
Immature domiciliary babies	28
TOTAL	108

Number of nursing visits to mothers	379
,, ,, ,, ,, ,, babies	1,337
TOTAL	1,716

PÆDIATRIC CLINIC.

Attendances—New	45
Others	174
Visits to clinic defaulters	13

Salford Part II Midwifery Training School

The very varied social problems and conditions in Salford give the students a wide experience and by spending six months on the district they are able to follow-through the care of their mothers and babies.

Nineteen students have completed their six months training during the year and all have now qualified as midwives.

The introduction of obstetric experience into the general nurse training has allowed for a wider use of our school, and students from Crumpsall Hospital have been introduced to midwifery in the home, and arrangements have been made for the same facilities to be available to trainees at Hope Hospital.

CARE OF MOTHERS AND YOUNG CHILDREN

Statistics

The figures in this section are compiled locally and do not necessarily correspond with those compiled by the Registrar General.

Births

Actual birth notifications and "transfers-in" received during the year were 4,041 live births and 106 stillbirths ; on adjustment there were 3,209 live births recorded for the City and 79 stillbirths, giving a Live Birth Rate of 20·77 and a Stillbirth Rate of 24·02 ; this is a satisfactory upward trend for live births as well as a satisfactory downward trend in stillbirths. The number of domiciliary births has risen this year—41·15% as compared with 38·3% for the previous year ; institutional births are 58·85%.

Infant Deaths

This is a dreary beginning to a section of the Annual Report which should be bright and full of promise, but nevertheless this aspect of child welfare work increases in importance as the number of deaths decreases. In 1942 the Infant Death Rate was 77 and for 1962 it is 28·04, subdivided as follows :—

Stillbirths 79
Deaths under 24 hours 36
„ 1—6 days ... 12
„ 2—3 weeks ... 3
„ 3—4 „ ... 1
„ 1—6 months... 30
„ 7—11 „ ... 8

127—Perinatal Death Rate 38·57

48 Early Neo-Natal Deaths—Death Rate 14·95

52 Neo-Natal Deaths—Death Rate 16·24

90 Infant Deaths—Death Rate 28·04

Causes and Age at Death	Under 24 hours	1–6 days	2–4 weeks	1–6 months	7–11 months	Total
Prematurity	22	5	...	...	...	27
Congenital Debility	2	1	...	...	...	3
Congenital Defect	5	2	2	4	1	14
Birth Injuries	4	2	...	...	...	6
Respiratory Diseases	1	1	1	18	6	27
Other Causes	2	1	...	4	...	7
Gastro-Enteritis	...	...	1	3	1	5
Accidental Death	...	...	...	1	...	1
TOTALS	36	12	4	30	8	90

We therefore see that 48 deaths occurred while midwifery care was still operative and that no deaths from prematurity, congenital debility or birth injury occurred after this period ; we see that deaths from congenital defect occurred up to eight months of age and that deaths from respiratory disease were heavier from 1–6 months of age, and also that *this group accounts for 25% of our infant deaths—as great a percentage of deaths from respiratory diseases as from prematurity* ! Gastro-enteritis is not recorded until after the post-midwifery period ; other causes extend up to the fifth month and the one accidental death occurred at three months.

Prevention

If we go through our deaths with an eye to prevention we see that reduction in some groups can only come about by hospital treatment or operations, some by combined hospital / home care ; others may be reduced by great emphasis on home care alone. Further research into the ante-natal period may assist in most groups.

In the field of *prematurity* a specially trained midwifery staff visit the home to advise and assist the mother, this service is backed by a weekly consultant clinic. The Premature Baby Service is dealt with more fully in the Midwifery Section of the Report.

Two of the deaths due to *congenital debility* were due to asphyxia (one with delayed labour) and one to cardiac failure.

We now come to the third largest group of causes. Three of the 14 deaths from *congenital defect* were domiciliary births but were transferred to hospital for further treatment. Six of the children lived less than one hour ; one child died at four days from Ecomelia (it was known that there was thalidomide therapy in the first trimester of pregnancy). Operations were performed on four children—one Blalock operation, one abdomino-perineal, one transverse colostomy, one dilation of pulmonary artery stenosis and one repair of meningomyelocele—all these children were over one month of age at death. In only four cases were health visiting calls made—chiefly due to early death or hospitalisation, the visits ranged from one to ten according to the age of the child. It is known that one child was a member of a problem family and that one mother requested no ante-natal care whatsoever, the midwife being called in when the birth was imminent. Family attitude to these children was reported to be adverse in two cases.

Six children died from *birth injuries*, three were hospital births, three were domiciliary births—one of these being transferred to hospital. Length of life was one to ten minutes for the four who died on the first day of life ; the remaining two lived only two days and the death of one of them was also due to sonne dysentery—it was reported that the mother herself had been treated for this for some weeks immediately prior to and up to the birth of her child.

There were 27 deaths from *respiratory diseases*, only three occurring during the first month of life, and deaths being recorded at all months of age except the eighth and ninth months. As may be expected, deaths were heaviest in the winter months—there were six in January—September and October had nil recordings. Twelve of these children were born at home and 15 in hospital. Records are available in 24 of the 27 cases. In view of the fact that deaths in this group occurred chiefly after the neo-natal period we must also

consider housing, home conditions and home care. It was found that the households were as follows :—

3 in modern corporation property.
3 ,, good flats in good larger type houses and areas.
1 ,, an average flat in a large-type house in a poorer area.
10 ,, terraced houses pre-1914 built but in good repair.
10 ,, two rooms up and two rooms down houses of even earlier erection. One was overcrowded and one was a "rates only" house in a poor state of repair.

Deaths occurred from virus pneumonia in two cases, onset of fatal illness was reported to be sudden in eight cases (four show a history of baby " snuffles," baby colds, family colds or family " chestiness,") ten deaths in all had previous histories of baby or family colds. Two of the children were reported to have poor lung development, two were premature (one was a twin) and one baby was a triplet. A reasonable number of visits were made by health visitors, but selective visiting does show in some cases. Although health visitors have many demands upon their services, one wonders whether routine health visiting up to twelve, eight, or even six months of age might assist in this field, extra emphasis being placed on this aspect of infant mortality and stressing the need for suitable clothing, adequate warmth (particularly the problem of cold bedrooms), fresh air and the need for other members of the family to " keep their colds to themselves." Are we too complacent about the " common cold "—particularly in households where young children are resident ?

Seven children died from *other causes*, length of life was from twelve hours to five months. One child was a member of a problem family and had been in and out of hospital several times prior to death in hospital at five months from septicæmia and gastro-enteritis. Another child died at two months due to cerebral sinus thrombosis, otitis media and upper respiratory tract infection—the fatal illness appeared to commence with a chest condition at three weeks of age. A six-months-old baby had operative treatment at two months of age for " intestinal obstruction," returned to hospital later and died from sub-dural hæmatoma.

Of the five children who died from *gastro-enteritis*, four died in hospital and one at home, poor home care or conditions are not reported in any of these cases ; one child (a triplet) was taken into hospital at two months with bronchitis, developed gastro-enteritis in hospital and died at three months.

The one *accidental death* was due to a serious fire in the home.

Deaths, 1–5 years

There were 15 deaths in this group (two more than in 1961) and are classified as follows :—

Cause of Death	Aged 1	Aged 2	Aged 3	Aged 4	Total
Accidents	1	2	1	1	5
Congenital Defect	...	2	2	1	5
Respiratory Diseases	2	...	...	1	3
Other Causes	1	1	...	...	2
TOTALS	4	5	3	3	15

The deaths from *accidents* were due to burns (3), drowning (1), motor accident (1), and emphasise the risk of unguarded fires, access to combustible materials and unsupervised play. They draw attention to the great need for incorporating safe playgrounds in areas of re-housing development. Investment in such would pay enormous dividends in the safety and happy development of our children.

All *congenital defects* show a history of continuous home and hospital care from birth.

One of the *respiratory diseases* was a virus pneumonia and the second death was also pneumonia of sudden onset ; the third death was a four-year-old who was also suffering from cerebral palsy—here again we have a history of "snuffles" and colds almost from birth.

In the *other causes* group one child died from leukemia—the first reports are on admission to hospital two weeks prior to death, the second child (who died from mucoviscidoses) had a very good history in the first year of life, but was admitted to hospital six weeks prior to death following a week of coughing and cyanosis.

Maternal Deaths

There were two maternal deaths in Salford in the year 1962, as recorded by the Registrar General, giving a Maternal Death Rate of ·6.

This compares with none in 1961, one in 1960, none in 1959, and none in 1958.

Both deaths were of patients who had been selected for delivery in hospital on account of obstetric indications. The cause of death was in one ruptured uterus, and in the second pilmonary embolism / elective Cæsarean Section.

In addition to these two maternal deaths there were two deaths of women from other causes occurring in the puerperium, one during the first week following delivery from sub-arachnoid hæmorrhage, the other on the twenty-second day after delivery from uterine bleeding due to thrombocytopeoenia. In the latter case there was lack of co-operation on the part of the patient in that she took her own discharge from hospital against medical advice.

Ante-Natal Clinics

At the end of February a new clinic was opened at Kersal and one of the Police Street sessions was transferred there. In June an appointment system for attendance was introduced, and by August was working smoothly, although both Murray Street and Langworthy clinics have high attendances with resultant over-long sessions periodically. Two hundred individuals per year per session appears to result in well-attended sessions with finishing times which enable the last-appointment mothers to be away in time to deal with schoolchildren, to allow midwifery staff a breathing-space before commencing evening visits and to enable clerical staff to reach the Central Offices with blood samples by 5 p.m.

The attached tabulation shows that 1962 was a busier year in the Ante-natal Clinics ; more individuals, with resultant increased total attendances, are recorded. Medical Officers continued to attend the sessions on alternate weeks ; consultations were slightly lower due to the fewer examinations now

carried out by the medical officers at these sessions consequent upon the implementations of the Cranbrook Report. In the first quarter of the year consultations totalled 863, but in the last quarter 677 were recorded.

The tabulation below shows the distribution of work between the various clinics, together with comparison of totals for the previous year :—

Clinic	Number of sessions weekly	Total individuals attended clinic	"Midwife Only" Sessions		"Combined" Sessions		
			Total attend-ances	"New" attenders	Total attend-ances	"New" attenders	Consul-tations
Encombe	1	137	341	43	422	57	200
Kersal	1	186	437	45	530	79	238
Langworthy	2	605	1,495	238	1,700	227	728
Murray Street	2	561	1,129	154	1,575	281	786
Ordsall	1	201	462	76	651	85	243
Police Street	1	179	492	80	521	95	270
Regent	1	272	681	109	746	120	324
Summerville	1	156	405	33	484	84	221
TOTALS	10	2,297	5,442	778	6,629	1,028	3,010
TOTALS–1961 ...	10	2,105	4,792	674	6,058	1,036	3,176

Blood Tests

The number of blood tests taken at Ante-Natal Clinics was as follows :—

For Wassermann and P.P.R. Tests, 1,406, of which seven were Positive.

For Hæmoglobin, 2,711. The great increase in the number of hæmoglobin tests is accounted for by the procedure commenced during the year of taking a repeat hæmoglobin test at the thirty-fourth week of pregnancy from each ante-natal patient. This is in accordance with modern practice.

For Rhesus Factor, 1,168. In addition, 401 patients attended the special Rhesus Clinic at Regent Road.

On re-testing, 271 mothers were reported as Rhesus Negative, of whom 203 were known Rhesus Negative cases, and 130 were reported to be Rhesus Positive.

Of the Rhesus Negative cases, 17 developed antibodies and were referred for hospital delivery. The results of these pregnancies were as follows :—

Four stillbirths.
One abortion.
One infant died within four hours.
Two cases were induced at 38 weeks—both the infants required exchange transfusion.
One case was induced at term—the infant required two simple transfusions.
In three cases the infants were mildly affected but transfusion was not necessary.
In three cases the babies were unaffected and no treatment was required.
Two mothers are still to be confined in 1963.

Post-Natal Clinics

This is the first year that post-natal examinations in local authority clinics is recorded as " Nil." Since 1948 fewer mothers have requested this service at local authority clinics. This is to be expected since the post-natal examination is an integral part of the complete maternity service undertaken by general practitioner–obstetricians for their patients, and in consequence is rarely carried out now at local authority clinics.

Child Welfare Clinics

In February of this year an additional child welfare clinic was opened in Lower Kersal. To a certain extent this drew some attendances from the Police Street Clinic, although statistics show that children attended at Kersal who did not normally attend a clinic elsewhere because of the distance to the nearest one from their homes.

The total attendances for the whole of the City was slightly lower than in 1961, although 359 fewer children attended. This is chiefly due to the drop in attendance by the 2–5 age group ; no doubt because of the decreasing need for poliomyelitis protection in that group.

The old townships of Salford, Pendleton and Broughton house three, four and two clinics respectively, and it is very interesting to note that the Broughton area clinics have been much busier this year. A further clinic is required for the Higher Broughton area to relieve the pressure on the Murray Street Clinic.

The following brief tabulation shows the attendances and consultations at the various clinics :—

Clinic	Attendances		Individuals		New Cases		Consultations	
	1962	1961	1962	1961	1962	1961	1962	1961
Cleveland	2,880	(2,999)	401	(482)	161	(180)	462	(545)
Encombe Place	1,607	(1,519)	320	(370)	157	(138)	274	(299)
Kersal Centre	2,052	(—)	364	(—)	155	(—)	371	(—)
Langworthy	9,471	(10,170)	1,773	(1,885)	666	(679)	1,731	(1,621)
Murray Street	7,699	(7,474)	1,631	(1,891)	714	(819)	1,747	(1,124)
Ordsall	2,336	(2,313)	445	(471)	171	(169)	506	(507)
Police Street	4,553	(5,427)	849	(1,138)	316	(445)	871	(1,135)
Regent Road	3,488	(3,867)	827	(975)	279	(369)	742	(769)
Summerville	2,731	(3,213)	375	(376)	129	(135)	385	(521)
Premature Baby (plus 48 who also attended other C.W.C.)	205	(180)	*30	(20)	35	(36)	200	(180)
Removed out in 1962 ...			353	(260)				
Clinic children died in 1962			14	(9)				
Became 5 years in 1962 and also attended in 1962			304	(168)				
GRAND TOTALS	37,022	(37,162)	7,686	(8,045)	2,783	(2,970)	7,289	(6,701)

* 78 individual children attended Premature Baby Clinic, but only 30 had not attended other clinics.

Plus polio vaccination attendance at special sessions : 1961—966 ; 1962—157

Age Group Statistics

The estimated child population in the under 5 years group was estimated to be 13,342 at 31st December, 1962, a decrease of 84 from the previous year ; the births for the five-year period concerned (1958–1962) were 183 higher than for the 1957–1961 period. The decrease in population was due to a higher " removal out " figure for the 1958–1962 years.

Transfer of records has shown that 13·6% of our 0–5 age group moved in or out of the City during the year, thereby proving the need for such a service in order that time is not spent by staff obtaining duplicate information regarding history and background. This service is also carried out between our own Child Welfare and School Health Sections when the children become 5 years of age.

The tabulation below shows the percentage of children in the various age groups who attended the clinics this year, together with the total attendances and the average attendances per child. The figures in brackets relate to 1961.

Age groups	Estimated number in group at 31st December		Number of children in group who attended a clinic in 1962		Percentage of children attended clinics		Total attendances of these children		Average attendance per child	
	1962	1961	1962	1961	1962	1961	1962	1961	1962	1961
0—1 ...	3,008	(3,031)	2,152	(2,072)	71·5	(68·36)	27,670	(27,038)	12·8	(13)
1—2 ...	2,836	(2,834)	2,229	(2,142)	78·5	(75·58)	5,600	(4,974)	2·5	(2·32)
2—5 ...	7,498	(7,561)	3,305	(3,831)	44	(50·56)	3,752	(5,150)	1·1	(1·3)
0—5 ...	13,342	(13,426)	7,686	(8,045)	57·6	(59·9)	37,022	(37,162)	4·8	(4·61)

Consultant Clinics and Hospital Liaison

Referral of children from child welfare sessions with the approval of the family doctor has continued throughout the year.

The pædiatric clinic work doubled this year and response to invitation was 86% ; there were 36 new cases. The premature baby clinic was well attended, 50% of the children attending being new cases and the remainder children who required further consultant attention. The orthopædic clinic shows a 50% rise in new cases referred. Response to invitation was 68%. Referrals to the ear, nose and throat clinic are rather low, but a response of 80% is made to invitations sent out.

One thousand three hundred and sixty-six reports from hospitals concerning out-patients or discharged in-patients were received during the year and have been circulated to medical and nursing staff concerned, afterwards being affixed to clinic records—if any.

These reports are duly forwarded to other areas or the School Health Service when children are known to leave the area or become five years of age.

Welfare and Proprietary Brand Food Sales

Selling points are established at all clinics as well as at the Hope Hospital ante-natal clinics. National Dried Milk was supplied in child welfare clinics and also at a central sales depot—there were 96 sessions per month in total. Vitamin supplements were supplied at all the previous selling points as well as at all ante-natal clinics in the City, including those held at Hope Hospital ; there were 152 sessions per month in total. The Hope Hospital distribution point is staffed by the W.V.S. and we are extremely grateful for their assistance in this field.

National Dried Milk sales have again shown a downward trend, with proprietary brand dried milks showing increased sales (particularly the lower-priced brands) ; the sale of evaporated liquid milks has declined.

Additional sales have also been recorded in the Cereal Foods and in the various miscellaneous products having both food and vitamin values.

Orange Juice sales are little different from the sales in the second half of 1961—6·7% of the estimated optimum uptake being recorded this year ; proprietary brand Vitamin C syrups again show increasing sales, no doubt partly due to the narrowing in price differential between National Orange Juice and these items.

Cod Liver Oil sales record a similar sales record to the previous year, the uptake being 3·3% of the estimated optimum uptake ; prescriptions issued for distribution of proprietary commodities in this field have been lower this year.

Vitamin A/D Tablet sales record 16·8% of the estimated optimum uptake being purchased by beneficiaries—a very slight rise over the second half of 1961.

Visits to Voluntary Organisation Mother and Baby Homes

There are two Voluntary Mother and Baby Homes in Salford. As in previous years visits to these were made by the Senior Assistant Medical Officer for Maternity and Child Welfare. Satisfactory conditions for the care of mothers and babies obtain in both homes. Though comparatively few Salford girls are admitted to these homes, the visits of the local authority representative are of value in providing an estimation of the over-all care in the homes, and of assuring the Matrons in charge of the interest of the local authority in their work.

Dental Care

The arrangements for dental treatment of expectant and nursing mothers and pre-school children previously in operation were maintained this year. No routine inspections were carried out, but treatment was given on referral by doctors, midwives, health visitors, etc., or on personal demand by the patient. Specific sessions were not allotted for this work, which was integrated with the normal working of the School Dental Service.

All forms of treatment are available, including X-rays and provision of dentures, which latter, when supplied, are fabricated under contract with an outside dental laboratory.

DENTAL CARE OF EXPECTANT AND NURSING MOTHERS AND CHILDREN UNDER SCHOOL AGE

(1) (*a*) Number of officers employed at end of year on a salary basis in terms of whole-time officers to the maternity and child welfare service :	
(1) Senior Dental Officer	—
(2) Dental Officers	—
(*b*) Number of officers employed at end of year on a sessional basis in terms of whole-time officers to the maternity and child welfare service...	—
(*c*) Number of dental clinics in operation at end of year	5
(*d*) Total number of sessions (*i.e.*, equivalent complete half days) devoted to maternity and child welfare patients during the year	30
(*e*) Number of dental technicians employed in the Local Health Authority's own laboratories at the end of the year	—

(2) DENTAL TREATMENT RETURN

A. NUMBERS PROVIDED WITH DENTAL CARE

(1)	Examined (2)	Needing Treatment (3)	Treated (4)	Made Dentally Fit (5)
Expectant and nursing mothers	180	180	159	133
Children under 5 years	477	472	390	360

B. FORMS OF DENTAL TREATMENT PROVIDED

(1)	Scalings and gum treatment (2)	Fillings (3)	Silver nitrate treatment (4)	Crowns or inlays (5)	Extractions (6)	General anæsthetics (7)	Dentures provided: Full upper or lower (8)	Dentures provided: Partial upper or lower (9)	Radiographs (10)
Expectant and nursing mothers	56	62	—	—	146	28	13	8	1
Children under 5 years ...	—	108	279	—	613	207	—	—	—

Physiotherapy Service

Physiotherapy in the health service has expanded fully from the old days when it was mainly concerned with giving a course of artificial sunlight to ninety babies, probably followed by massage for their bowing legs.

Fortunately today a tendency towards rickets is extremely rare, but there are still a number of minor defects which can be soon cured if treated early, and whenever there is available room we like to hold a session in conjunction with Welfare Clinics, so that close liaison can be obtained with the health visitors and welfare doctors, and the mothers can feel that they are benefiting from a co-ordinated service.

We are very anxious to treat any baby who may have a more lasting handicap such as cerebral palsy from as early an age as possible, because only by so doing can many structural defects be prevented and education in making the best use of acquired skills be encouraged.

Helping the mentally handicapped (both children and young adults) is a new field of work and probably because of the shortage of physiotherapists has not been extensively used in any health service previously.

We have now continued this work for a sufficient length of time to feel that we are helping in the education of the mentally handicapped. Progress is naturally very slow and there are no spectacular results, but if we can prevent deformities from developing and are able to help both the children and adults to move freely then in contributing in a small way towards human happiness something worthwhile has been achieved.

Some further progress has been made in helping with the geriatric clinics. Unfortunately, as our work is primarily for mothers and babies, when we have an acute shortage of physiotherapists this branch of the work has to be reduced. The old people are most appreciative of the help given and of the feeling of better health which results from breathing exercises and possibly some heat and gentle exercises for rheumatic joints.

The non-hospital air of the clinics and the cup of tea we make if time permits probably does more to give them a psychological feeling of better health than bottles of medicine.

Ante-natal relaxation classes have been held at four centres in conjunction with the midwives and medical officers clinics. The midwives assure us that the mothers are more relaxed and confident when in labour and are helped by the practice and discussion at the classes.

Wherever possible we try to visit day nurseries so that a child is not deprived of necessary treatment because the mother is working, but again it is not always possible to spare a physiotherapist to visit a day nursery as it is so time-consuming.

If only we could be sure of being fully staffed much long-term planning could be done, but unfortunately there are still long periods of acute shortage and it is very disheartening to have a new project just showing results when it suddenly has to close down for want of a physiotherapist.

Special Medical Examinations

No case was referred for examination by the Police or Probation Officer during the year 1962.

Two 16-year-old girls were examined for the Children Department as urgent cases requiring placement. One girl was pregnant and was admitted to a Mother and Baby Home. The second was not pregnant and was admitted to a Training Centre.

Examinations of Children for Adoption

Six girls and seven boys were medically examined prior to adoption in the year 1962. The referring agency was the Salford Children Department in the case of 11 children, the County Court Officer in the case of one child, and a Voluntary Adoption Society in the case of the remaining child. All the children were passed as fit for adoption. The total of 13 children examined compares with nine for the year 1961 and 12 for the year 1960.

DAY NURSERIES

Attendances and Admissions

The five Day Nurseries in the City, which can accommodate 85 children under 2 years of age and 150 between the ages of 2–5 years, were open all the year. At the beginning of 1962 there were 212 children on the registers and 221 at 31st December. The average daily attendance during the year was 45·6 for the 0–2 years group and 113·7 for the 2–5 group. Reasons for lower attendances were due chiefly to dysentery in the earlier part of the year and measles from October onwards.

A survey on attendance figures showed average attendances ranging from 69 to 220 in the individual weeks ; tabulated below is the range and reasons given for low attendance covering the entire year :—

Average Attendances.	*Reasons given for Low Attendances.*
69 Christmas week	Main holiday periods—parents off work.
96 August week	
96 New Year week	
105 Whitweek	
114 Last week in July	
141 — 149 for 9 weeks of the year.	Dysentery, measles, colds and influenza.
151 — 159 ,, 9 ,, ,, ,,	Dysentery, measles, colds and influenza.
160 — 170 ,, 10 ,, ,, ,,	Colds, coughs, mumps, dysentery, measles.
171 — 179 ,, 14 ,, ,, ,,	Dysentery, mumps, measles.
180 — 187 ,, 3 ,, ,, ,,	
200 (mid-Sep.) 1 week ,, ,,	
220 (early Oct.) 1 ,, ,, ,,	
52 weeks.	

During the year there were 242 discharges and 290 admissions, thereby, in effect, re-filling all places at least once during the year. Of the admissions, 91 were short-stay cases (i.e., eight weeks or less), the length of stay varied according to the reason for admission in all cases ; distribution of admissions and length of stay were as follows :—

Length of Stay	Bradshaw Street	Eccles Old Road	Hayfield Terrace	Howard Street	Hulme Street	Totals
Under 2 weeks ...	5	10	2	...	7	24
2—4 weeks	3	4	5	8	12	32
4—8 ,, ...	11	2	3	14	5	35
8+ ,, ...	40	31	38	38	45	192
Admissions since November	...	5	2	...	...	7
TOTALS	59	52	50	60	69	290

The reasons for admission were carefully considered before places were granted and these were allocated according to the reason. In March a comprehensive register was commenced showing distribution of places granted according to category, the statistics below give the placings at 23rd March and again at 31st December. It will be noted that two-thirds of all places are granted for non-financial reasons, although many " financial " admissions are prevented from becoming " acute social " admissions if the mother is able to earn an income. Charges are in accordance with income and an approved scale of admission fees. Waiting lists have been reasonable at Eccles Old Road, Hayfield Terrace and Howard Street Nurseries ; Bradshaw Street is always very high—127 children were on this waiting list at the year-end, of whom 123 were classified as financial ; Hulme Street waiting list has been low, particularly during the latter half of the year.

Category	On Registers on 23/3/62	On Registers on 31/12/62
Illness of parent or confinement	22	17
Acute social problems	25	33
Divorced parents	3	4
Unmarried mothers	30	27
Separated parents	25	32
Widowed parents	12	10
Orphaned child	1	1
Mother in essential employment	10	9
Handicapped (parent or child)	9	11
Financial	75	77
TOTALS	212	221

Admissions are also dependent on the staffing position, thereby ensuring that sufficient staff are on duty to care for children attending.

Medical Report

A medical officer has paid regular visits to the Day Nurseries as in previous years. Fifty-two visits were paid in respect of the five Day Nurseries, a total of 289 individual children were examined. All new entrants were examined as soon as possible after entry. Very few children had such a short stay that they were never examined. The chief defects found were genu valgum and enlarged tonsils and adenoids—there was one case of hydrocœle, and one of umbilical hernia.

The following table gives the incidence of infectious diseases occurring in the Nurseries during the year :—

Nursery	Measles	Chickenpox	Sonne Dysentery	Non-specific Diarrhoea and Specimens Taken	Whooping Cough	Rubella	Broncho-Pneumonia	Mumps
Hayfield Terrace	...	20	14	...	...	2	...	...
Bradshaw Street	23	2	12	...	...	4	...	3
Eccles Old Road	23	30	3	14	1	1	1	...
Hulme Street	19	...	2	...	...	1	...	...
Howard Street	27	...	19	...	...	4	...	...
TOTALS	92	52	50	14	1	12	1	3

The high incidence of infectious diseases in the nurseries this year has had an adverse effect on the attendance rate ; in the case of dysentery restricting the admissions for periods of several weeks. There were 50 cases of Sonne dysentery affecting all nurseries in the early months of the year—in 1961 there were only 17 such cases. In the autumn, measles and chickenpox were prevalent, there being 92 cases of the former and 52 of the latter, as compared with 82 cases of measles and none of chickenpox in 1961.

There were 11 children with special difficulties on the register as at 31st December, 1962. Of these, one had a visual defect, two had speech defect, one had an artificial arm, two had psychological disturbance, five children had severe social handicap because of the mental or physical disability of the mother.

Courses of Ultra Violet Ray therapy have been given in the nurseries by the Matrons, and remedial exercises by the staff of the Physiotherapy Department, in each case on the recommendation of the Medical Officer.

Immunisation procedures have been performed in the nurseries, namely booster doses of triple antigen for protection against diphtheria, tetanus and whooping cough, and vaccinations against poliomyelitis were performed. In addition, during the intensive smallpox vaccination programme in the City, this was extended to include the children attending Day Nurseries.

Staff

In addition to annual leave during 1962 there were 565 staff sickness days, 91 days of special leave or absences for other reasons, plus attendances at Refresher Courses with consequent staff absence from nurseries. During the year the following vacancies have occurred, with resultant periods without such staff until new appointments were made :—

One Matron (due to retirement of a staff member who had been a Salford Day Nursery Matron since the opening of the War-time Day Nurseries).

Two Deputy Matrons (one due to promotion to Matron).

One Warden.

Three Nursery Nurses (one due to promotion to Deputy Matron and one to promotion to Warden).

Four Nursery Assistants.

Nine new appointments were made during the year ; at 31st December one post of Deputy Matron and one of Nursery Nurse were still unfilled. There is great difficulty in recruiting trained staff ; the shorter hours and longer holidays afforded by Nursery School appointments appear to attract trained staff ; the additional salary for Day Nursery duties is apparently not considered when an appointment is being sought.

Refresher Courses and Students

One Matron attended the Matrons Association Conference at Llandudno on 7th and 8th April, 1962. A detailed report of the lectures and discussions was submitted.

Two Matrons attended a Refresher Course at Southall Street Training Centre, Manchester, from 16th to 25th May.

One Deputy Matron attended a Refresher Course at Manchester from 21st to 30th March.

One Warden (qualified Nursery Nurse) attended a Warden's Qualifying Course at Manchester from 1st to 19th October.

Two Wardens attended a Refresher Course at Manchester from 5th to 11th November. The Principal of the Centre expressed great satisfaction with their work.

Two Nursery Assistants attended a Refresher Course at Manchester from 26th to 30th November.

The five students for the Nursery Nurses Examination Board Course appointed by the Health Committee were all successful in the examination in 1962 and obtained the certificate. One of these was appointed as Staff Nurse in a Salford Corporation Day Nursery, subsequent to her qualification.

Five new students were appointed to the course in September, 1962. Unfortunately, one of the most promising tendered her resignation in November due to her parents removal to the South of England. One of the previously unsuccessful but suitable applicants was still available and was appointed to fill the vacancy.

One of the Day Nurseries was visited by Her Majesty's Inspectors and continued approval was given to its use as a training centre for students for the Course for the Certificate of the Nursery Nurses Examination Board.

INCIDENCE OF BLINDNESS

A1. Registered Blind Persons.
A2. Registered Partially Sighted Persons.
B. Ophthalmia Neonatorum.

A1. Follow-up of Registered Blind Persons.

Total number of cases registered during 1962 — 33.

	Cause of Disability			
(i) Number of cases registered during the year in respect of which Section F (1) of Forms B.D. 8 recommends :—	Cataract	Glaucoma	Retrolental Fibroplasia	Others
(*a*) No treatment	6	1	...	11
(*b*) Treatment—				
Medical	3	1	...	8
Surgical	1	...	...	...
Optical	...	1	...	1
(ii) Number of cases at (i) (*b*) above which, on follow-up action, have received treatment.	2	2	...	9

A2. Follow-up of Registered Partially Sighted Persons.
Total number of cases registered during 1962 — 36.

	Cause of Disability			
(i) Number of cases registered during the year in respect of which Section F (1) of Forms B.D. 8 recommends :—	Cataract	Glaucoma	Retrolental Fibroplasia	Others
(*a*) No treatment	3	...	...	2
(*b*) Treatment—				
Medical	2	4	...	5
Surgical	3	...	...	1
Optical	7	2	...	7
(ii) Number of cases at (i) (*b*) above which, on follow-up action, have received treatment.	8	6	...	11

B. Ophthalmia Neonatorum

(i) Total number of cases notified during the year	Nil
(ii) Number of cases in which—	
(*a*) Vision lost	Nil
(*b*) Vision impaired	Nil
(*c*) Treatment continuing at end of year	Nil

HANDICAPPED CHILDREN AGED 0-5 YEARS

The care of the handicapped child continues to assume an increasing importance in the work of the Child Welfare Service. To this end early ascertainment of cases, follow-up of cases, assessment of disability, and correction as far as possible by remedial treatment and training, with the aim of ensuring as normal a life as possible for the child, and of selecting the most suitable form of education well in advance of his need, is the primary object of the compilation of the Handicapped Children Register.

After allowing for removals, fatalities, cures, and children transferred to the School Health Service at five years, the numbers on the register on 31st December, at the end of each year over the five-year period 1958–1962, are as follows : 1958, 168 ; 1959, 189 ; 1960, 189 ; 1961, 194 ; 1962, 219. The increase in numbers does not necessarily represent an actual increase in cases, but rather an improvement in awareness of the importance of the register and of early detection and notification of cases.

Of the 219 cases recorded, 182 children had a single defect, 33 had two defects and 4 had three defects.

The following table gives the defects from which the children are suffering and the numbers in each category :—

Blind	2
Partially sighted	6
Other eye diseases	5
Deaf	7
Partially hearing	4
Delicate respiratory conditions	11
,, circulatory ,, ...	34
,, gastro-intestinal ,, ...	9
,, genito-urinary ,, ...	3
,, miscellaneous ,, ...	28
Epilepsy	11
Recurring convulsions	11
Mental subnormality	58
Cerebral palsy	6
Other diseases of the nervous system	28
Orthopædic conditions	33
Speech defect	4
Total	260

Of the 37 children suffering from more than one defect the following table gives the numbers of children concerned and the combination of defects present :—

Mental defect hydrocephalus, flail foot	1
,, ,, and hypopituitarism	1
,, ,, ,, osteomyelitis femur	1
,, ,, ,, convulsions	3
,, ,, ,, post measles encephalitis	1
,, ,, ,, multiple congenital defects	2
,, ,, ,, epilepsy	4
,, ,, ,, cerebral palsy	4
,, ,, ,, cleft palate	1
,, ,, ,, congenital heart lesion	3
,, defect, partially sighted and epilepsy	1
,, ,, blind and Klippel-Feil's Syndrome	1
Cerebral palsy and epilepsy	1
,, ,, ,, congenital heart lesion	1
Spina bifida and severe epispadias	1
,, ,, ,, talipes	1
,, bifida, congenital heart lesion, Klippel Feil's Syndrome	1
Multiple congenital defects and Klippel-Feil's Syndrome	1
Partially sighted and other eye defect	5
Congenital heart lesion and partial hearing	1
Asthma and eczema	1
Extensive nævus face and epilepsy	1
TOTAL	37

Forty-four children reached five years during the year and required educational provision as follows :—

Ordinary School	21
Open Air School	9
Mental Health Training Centre	4
Parkfield Special School	1
Cleveland House School for Spastic Children	1
Home teaching	1
Class for Partially Hearing Children	2
E.S.N. Special School	1
Residential School for the Blind	1
Residential School for the Deaf	2
Orthopædic Hospital School	1
TOTAL	44

The names of 103 children were removed from the register for the following reasons :—

Fatal	14
Cured	24
Removed	21
Reached five years	44
TOTAL	103

CONVALESCENCE

During the year there were applications from 40 households requesting convalescence for mothers and young children ; children on their own ; adults of working age or older, as well as some referred specifically because they suffered from bronchitis. These applications were concerned with 15 mothers, 36 children and 25 adults.

As is usual the cost of care for the young children was borne by the local authority, all adults (including mothers) being asked to pay towards their maintenance according to their income. Those who are able to pay the full cost of maintenance rarely apply to the department—no doubt making their own arrangements for a recuperative holiday. It is significant, however, that a request of even £1 per week towards maintenance can sometimes result in a " non-follow-up " or a statement that various non-monetary factors will preclude the acceptance of the place at the Convalescent Home.

The requests were dealt with as follows :—

Mothers and Young Children

Cathedral Homes—Mellor

This is a simple establishment providing a free " roof " ; mothers buying and cooking their own food, paying a nominal sum towards pooled expenses incurred for cooking facilities, etc.

One mother and one child went for one week.

One mother and two children went for one week (the four elder school-children went to the Wood Street Mission Home at St. Anne's at the same time).

One mother with four children was unable, due to home difficulties, to take the places allocated to her.

One mother and four children did not follow up the request.

One mother and four children did not follow up the request.

Grey Court, Lancaster

This is primarily a Holiday Home and will take mothers with children over three years of age and also recuperative patients who need " jollying-up." In view of the nature and standard of the Home it is necessary to select applicants so that they are not out of their element.

One mother and one child went for two weeks.

One mother and one child were booked for two weeks but did not take up the booking.

Blackburn and District Convalescent Home

One mother was sent here for two weeks while her young son went to Abergele via the Invalid Children's Aid Association.

Brentwood, Marple

One mother and two-weeks-old baby were sent to Brentwood for four weeks for post-B.C.G. isolation.

Not followed up

Three mothers, each with one child—no reason given.
One mother with two children—no reason given.
One mother with one child—mother eligible for Hospital Saturday Fund convalescence.
One mother with two children—stated she did not wish convalescence.

Children on their own

All such children are referred to the Invalid Children's Aid Association and are sent to suitable Homes for their age groups. The six referred were dealt with as follows :—

Abergele : Three children went for four weeks each.

Ormrod Home, St. Annes-on-Sea : One child was sent for four weeks but was brought home by the parents after nine days.

Not followed up : Two children were referred for Day Nursery care as it was ascertained that the mother's imminent confinement was the reason for request. Day Nursery care was not followed up by the mother.

Adults

This group can be divided into three, or perhaps four, groups :—

(1) The over 60–65 age group who are (*a*) referred to the Civic Welfare for places in Civic Welfare Homes ; it is furthermore very rare for the usual Convalescent Homes to admit patients over 70 years of age ; (*b*) referred to the British Red Cross Society if accommodation is required while their children themselves take a holiday in the knowledge that their aged parents are being cared for ; (2) The patients of working age referred by general practitioners as having bronchitis and needing a change of air—such cases are referred to the Civic Welfare Department ; (3) The patients of working age who are referred for convalescence to enable them to return to their work ; (4) The mothers who do not have a job outside the home, have no young children, but need a period of recuperation to enable them to continue caring for their families as they would wish to.

The 25 cases in this group were dealt with as follows :—

Four women and three men were referred to the Civic Welfare on age grounds.
One woman (over 60 years) did not wish for convalescence—the request came from her son.
Three men were referred to Civic Welfare as bronchitis patients.
One woman to the Lear Home of Recovery at West Kirby for two weeks (she returned home after only five days).
Three women to Blackburn and District Convalescent Home at St. Annes-on-Sea for two weeks (one of them stayed for one week only).
Two women offered Blackburn and District Convalescent Home places for two weeks but did not follow up the offer.
One woman offered Grey Court for two weeks but did not follow up the offer.
One woman eligible for Hospital Saturday Fund care—advised.
One woman and two men did not follow up—reason not stated.
Two women wished to defer convalescence till later.
One woman not proceeded with—had attended a Convalescent Home the previous year (arranged by this Department) and she was not eligible for a place at the Home two years together.

HEALTH VISITING SERVICE

Combined health visiting and school nursing was carried out by general health visitors under the direction of the Superintendent Health Visitor. Five specialist health visitors continued to assist by acting in an advisory or liaison capacity to the general staff in relation to the special fields of work with which they were concerned. Work connected with aged infirm persons, the majority of whom live outside a family group, was carried out mainly by specialist staff.

At the end of the year the total staff numbered 63, of whom 46 were professionally qualified workers, two were student health visitors and fifteen nursing auxiliaries.

General Health Visiting

There was a further decline in the number of visits paid for all purposes. This was due to staff shortage and concentration of effort on immunisation in clinics and schools.

Selective visiting continued and families at risk received special attention as in former years. There was a considerable increase in the number of evening visits paid.

Special Health Visitor Services

(*a*) Elderly Persons

There was a marked increase in the number of persons referred to the section during the year—1,232 against 953 last year.

A total of 4,728 cases were dealt with. Over two-thirds were women.

STATE OF ACTIVITY

Bed-ridden	149
Home bound	151
Semi-ambulant	255
Ambulant	677

Cases were referred by :—

Civic Welfare	170
Found by Health Visitor whilst visiting other elderly people	120
General Practitioners	79
Health Visitor (area)	18
Home Help Service	20
Hospitals	111
Mental Health Service	5
Relatives, friends and personal application	527
Public Health Inspectors	17
Voluntary Organisations	3
Housing Department	25
District Nurses and other statutory organisations)	137
	1,232

Reasons for Referrals

Alone and neglected	1
Cancer conditions	18
Chest ,,	63
Diabetic ,,	36
Nephritic ,,	4
Rheumatic ,,	113
Senile mental conditions	37
Vascular conditions	63
Heart ,,	54
Nervous diseases (Parkinsons Disseminated Sclerosis)	36
Blind	11
Deaf	26
Other conditions	352
Chiropody	418
	1,232

State of Activity (new cases)

Bed-ridden	149	12%()
Home bound	151	(12·2%)
Semi-ambulant	255	(20·6+)
Ambulant	677	(55%)

Some of the problems which the health visitor finds among the elderly are not in themselves direct "health" problems, but they cause anxiety, distress and sometimes a lowering of living standards, all of which may, and often do, lead to a deterioration of both mental and physical health.

The service aims to promote the health and well-being of elderly persons, to keep them out of hospitals and institutions, and to keep them healthy, happy and mobile in their own homes for as long as possible. Elderly persons living alone needed the most help. Housing problems were again a difficulty. Moving house is a tremendous upheaval for many old people ; and in some cases, where rehousing is from property due for immediate demolition to condemned property due for delayed demolition, means eventually another removal which is very upsetting for the old folk. At Kersal Flats some of the flats occupied by old people are the loneliest dwellings imaginable. Ten storeys high, the central lift opens into an artificially lit central area on each floor which has four front doors opening into it. There are no stairs here. If the lift breaks down the tenant or caller is trapped as it is impossible to get down to the ground floor again without going through someone's flat to the back stairs. Each flat has a small verandah and a back door ; the sink faces a blank wall. Tenants who are active can get out and about. For many of the elderly, however, their world is reduced to the flat and about six feet of verandah. Another point is that the lifts are self-operative and old people are often afraid to use them. All forms of electrical equipment hold fears for people who have never been used to electricity, and many old folk prefer to face the exhausting climb upstairs rather than use the lift. All these circumstances operate against the efforts of the health visitor to secure comfort and well-being for the elderly persons concerned.

Then there is the " problem " group of elderly persons who have deteriorated mentally and physically—who fail to cook or provide proper food for themselves ; who neglect their personal cleanliness and their homes. These people, usually living along are often neglected by their relations and require much help and encouragement. Some are pathetically eager to retain their " homes "—either refusing to see a doctor if ill for fear hospital is suggested or refusing to enter hospital if advised to do so. One such man,

ill as he was, went out every day and stayed out to avoid callers who might arrange his admission to hospital against his will, and part him from his little dog. He died alone.

An elderly woman who had lived alone for ten years kept six cats, hoarded rubbish and would rarely open the door to visitors. Every fortnight she would tidy one room when the rent collector was expected—mainly because she was afraid of eviction and parting from the cats.

She became ill and was removed to hospital in emergency. The cats were taken by the R.S.P.C.A. The home was filthy. Her niece, living nearby, refused when asked to assist with cleaning—neighbours refused to touch the revolting rooms—no-one would help. The health visitor then approached a local priest —he arranged for a group of young volunteers to tackle the problem. They scraped and scrubbed floors, bought and laid new linoleum, made and hung new curtains, decorated the walls. A neighbour gave a bird to console the old lady following loss of the cats. The patient was discharged from hospital— the health visitor arranged for a home help, regular bathing by a nursing auxiliary, meals on wheels (none of which she would previously accept), and a weekly visit by ambulance to the Cripples Club where she was sometimes asked to play the piano. These arrangements have meant the opening of a new life for her and she has responded extremely well. This is only one of several cases helped by the Church.

Fifteen nursing auxiliaries are made available part-time to offer assistance with bathing and foot hygiene to persons selected by the health visitor. These services are of great value and are much appreciated by the old folk—even by those who in the first instance resist all efforts to help them. Many of our nursing auxiliaries have great understanding of old people, and skill in dealing with difficult cases.

Cleansing

Conditions remain unsatisfactory in that we have no premises for cleansing and disinfestation.

Clinic for the Elderly

For several months during the year the clinic for women was suspended following the resignation of the doctor. During the remainder of the year a weekly session was shared by men and women—half the session being devoted to men, the other half to women. Physiotherapy was provided for appropriate cases at Langworthy Centre.

Hospital Admission

Liaison between hospitals and health visitors was good—there were regular meetings between the geriatrician and the special health visitor in charge of services for the elderly. The opening of another ward for women at Ladywell greatly reduced the waiting list, and few patients now have to wait more than a few days before admission.

Liaison with Family Doctors

There was good co-operation between general practitioners and the health visitor. Many patients referred were already known to us. Referrals may be made personally, by telephone, or by the official stamped reference card.

Co-operation with Other Agencies

Frequent contact was made with the National Assistance Board. Many cases were referred to us by the Civic Welfare Department—mainly with reference to chiropody and home helps.

The District Nursing Service was able to make available nursing equipment and the domiciliary laundry service when required, as well as to offer nursing in the home when required. Another service of inestimable value to the elderly was that of the home help ; the organiser of this service also arranges a night-sitter service.

The Health Department's Bring and Buy Sale proceeds were divided between the Children's Welfare Fund and the Elderly Persons' Fund. Through the latter we were able to provide fireguards, walking sticks, saucepans, contributions towards television licence holiday, re-decoration, taxi-fare for wife to visit husband hospitalised outside Salford.

Pupils from Clarendon Secondary Modern School took baskets of fruit to elderly persons named by us.

Claremont Open Air School sent their harvest fruit and gifts to us. We were able to send out boxes of fruit to at least fifty old people and to send tinned and other dry goods to others at Christmas time.

Through Dickanson's Charity we were able to procure boots or shirts for sixteen needy elderly men.

	Cases referred during 1962		Cases already on the Register		Total	
Died : (*a*) Males	16	53	148	430	164	483
(*b*) Females	37		282		319	
Admitted to Hospital	39		412		451	
Admitted to Local Authority Home	9		44		53	
Admitted to Jewish Home	—		4		4	
Left District	28		91		119	

Total Number remaining on register at 31st December, 1963—4,059, of these 1,573 (38·7%) were living alone.

(*b*) **Liaison—Chest Clinic**

The special health visitor continued her work in this field as formerly. There was a fall in the number of patients notified as suffering from pulmonary tuberculosis—70 notifications compared with 106 last year. As in all types of hospital liaison work the health visitor effects an interchange of information between hospital or clinic and the health department. All new Salford patients attending the chest clinic are interviewed by the special health visitor, plus any old patients with problems.

Matters concerning the health visitor include possible admission of the patient to a sanatorium, contact examination, health education, advocation of B.C.G. vaccination in all appropriate cases, the discussion of family or individual problems and referral, where necessary, to appropriate social agencies.

One of the most difficult problems is concerned with the patient who has developed drug-resistant organisms, as he is likely to become a danger to others, as well as being a difficult patient to treat.

Patients suffering from other chest illnesses were also the concern of the health visitor, particularly the lung cancer cases. Problems relating to loss of work and lowering of living standards increase the natural anxiety of a patient whose symptoms become progressively more manifest. Special home visits were paid to both patients and relatives who needed the support, encouragement, and help of the health visitor. The health visitor continued to attend the Consultant Thoracic Surgeon's Clinic held at Ladywell every month, and she paid special home visits to both patients and relatives who were in need of her support and encouragement.

Patient interviews	231		
Doctor ,, ...	143		
Almoner ,, ...	12		
Special visits to patients	80		
Mantoux Tests	332	negative (Post- and Pre-B.C.G.)	124
		positive (,, ,, ,,)	208
B.C.G.	222		

(*c*) Hospital Liaison

The special health visitor responsible continued this work as in former years—visiting certain wards in Hope and Ladywell Hospitals and the Diabetic Clinic at Salford Royal.

Hope Hospital

As new patterns emerge in the day-to-day hospital and health visiting routines, so gradually do the needs for and methods of liaison change. There is now a greater selection of cases by the Ward Sister rather than ad hoc referral of all children admitted ; and children needing special care receive special consideration, e.g., in cases of :—

Home accidents.

Feeding difficulties.

Children found to be dirty and/or verminous on admission.

Children who are not visited whilst in hospital.

Children for whom no physical cause can be found in relation to signs and symptoms of illness.

Extremely nervous, inexperienced, or over-anxious parents.

It was found that the greatest need for close liaison was required when dealing with the tinker or gipsy type of family. These people have no settled abode, often being allowed by the police to spend only a few nights in any one place. Although seemingly fond of their children, these people cannot appreciate the need to keep in close touch with the hospital or to leave an address where they can be found They frequently fail to keep subsequent out-patient appointments, and it is difficult to keep track of the children, who are often the ones most in need of supervision and their parents of guidance.

One valuable aspect of liaison is in connection with the discharge home of premature infants, as assessment of home conditions in relation to the needs of small babies is important, especially during the winter months when there is a very real risk of cold injury.

Ladywell Hospital

Weekly visits to Ladywell continued throughout the year. The health visitor's main concern was with home follow-up of children suffering from gastro-intestinal infections.

Salford Royal Hospital

The attendance of the special Liaison Health Visitor at the Diabetic Clinic, which was started at the end of last year at the request of the Consultant Physician, continued throughout 1962. It was soon decided that the health visitor should pay weekly rather than monthly visits to the clinic in order to meet the problems arising. Some diabetic patients become confused about the dosage of drugs, diet, urine testing and so-on, and home follow-up is extremely important in these cases. In the case of elderly diabetics, supervision is doubly important, as these patients sometimes also have accompanying deterioration of vision. This condition may give rise to serious difficulties in relation to care of the feet as the diabetic patient is liable to cause grave harm to himself should he inflict even mild trauma whilst carrying out ordinary foot care. The health visitor arranges chiropody treatment, which is of great value to these patients.

Close collaboration with the District Nursing Service, which is especially important in liaison work of this kind, has been fully—and promptly—given, and has been of the greatest help in this work.

The number of diabetic patients referred to the health visitor during the year was 51, to whom 128 visits were paid. Cases domiciled outside the city boundary were referred by the health visitor to appropriate authorities.

(*d*) **Prevention of Family Break-up—Neglected Children**

The aims and organisation of this section of the Health Visiting service continued as in former years, with a special health visitor responsible for the work.

The Register of " problem families " was maintained. Fifteen new cases were added to 246 families carried over from 1961, and two old cases were reopened.

There was, in addition, an increase in the demand for assistance with family problems (238 against 201 in 1961). These problems were wide, varied, and time-consuming. All were of a medico-social nature, some threatened break-up of the family. Problems of desertion and the need to arrange for alternative care of the children were prominent features of this work.

A further extension of the service was made with families of persons, mainly men, serving prison sentences—76 were referred, of whom 50 required help. We were unable to trace seven of these families—the remaining 43 were dealt with.

Details of this expansion of the service are given rather fully as the work is comparatively new to the section. The aims are as follows :—

1. To form a relationship with the wife and mother, with the ultimate aim of influencing the prisoner towards taking his place in the community and in employment on his release.
2. To give help and support to wife and children during father's absence.
3. To prevent family break-up. Some wives feel reluctant to take back their husbands on discharge and feel very keenly the stigma of prison.
4. To encourage membership of the mother to a club or group in an effort to avoid boredom, loneliness and possibly infidelity with all its consequences.
5. To assist in making adequate financial arrangements regarding income and commitments, and in making the best use of the social services, both statutory and voluntary, to the benefit of the family.

The practical problems which presented themselves most frequently in this field were :—

1. Adjustment.
2. Debts.
3. Accommodation.
4. Separation.
5. Unemployment.

Adjustment

Immediately after the husband's committal to prison many wives appeared to flounder, and a visitor who was ready to listen to their difficulties and look after the families' interests was very welcome. Appropriate cases were referred to the National Assistance Board for the Statutory Allowance and in some cases for the Special Needs grant. Free school meals were arranged, also clothing and footwear in appropriate cases from the School Welfare Department. For mothers and younger children approach was made to the W.V.S. for second-hand clothing where required.

When mothers became ill or were confined the Health Visitor made alternative arrangements for the care of the children, using relatives, daily-minders and day nurseries where appropriate. Only as a last resort was the Local Authority requested to provide temporary accommodation.

Emotional adjustment is often the most difficult of all, as the wife not only suffers humiliation of her husband's misdemeanour and punishment, but usually she tries to keep the fact of his imprisonment to herself. She may conceal the truth from her children by saying father is working away, or is in hospital, only to find that someone outside the family has told them the truth. This often proves disastrous as the child not only feels ashamed of his father but has also been let down by his mother who has lied to him. The mother may become depressed and miserable and intolerant towards her children, and the children may develop behaviour and other problems indicating emotional insecurity, *e.g.*, nocturnal enuresis, nightmares, truancy, and so on.

The Health Visitor seeks to prevent these developments by supportive care through personal case-work from the outset. She may encourage or arrange membership of a Mothers Club or a social church group, or other outside interests.

Debt

The Health Visitor dealt with this by negotiating acceptable arrangements for payment with landlords, hire purchase firms, gas and electricity boards and County Court bailiffs—sometimes by payment of small weekly sums, sometimes by complete suspension of payment until the husband's release. In some instances financial help from various charity organisations was secured in order to facilitate negotiations.

Accommodation

Many families living in houses in multi-occupation were issued with Notices to Quit following the husband's committal to prison. This threat of being rendered homeless, in addition to being deprived of her partner, was more than some wives could take, and psychological problems developed which were sometimes reflected in the behaviour of the children.

In such cases the health visitor would provide particulars of sub-let accommodation but the onus of acquiring suitable rooms was placed on the mother. Places were found in appropriate cases for the admission of children to Greengate Day Special School.

Separation

It is unfortunate, but true, that the prisoner's family may suffer more than the offender. The latter has a prison welfare officer to hand whenever he wishes to discuss any problem and the prison welfare officer does not hesitate to make contact with the health visitor should it concern the family or any external matter. It is only when the wife fails to write or visit that one finds she has been overwhelmed by everything and her morale is so low she feels unable to cope with her husband any further. It is only after arranging many discussions and interviews at H.M. Prison that reconciliation may be achieved.

Unemployment

This presents a very real problem for the prisoner on discharge as, although it is true that some firms are reluctant to employ a man with a record, many of the ex-prisoners are very inadequate persons with a low earning capacity and the present social benefits exceed their market value. There was good liaison between the health visitor and probation officers and other officials concerned with this problem.

At the end of the year in all but three cases the families remained intact as a unit, where father would be welcomed on his release. Two of the remaining three were threatened with family break-up but finally were reconciled ; the third family disintegrated, partly due to the husband's mental instability and partly to the wife's infidelity.

The additional work entailed in this development of the service made it necessary to second another health visitor from the general staff to assist with the case-work involved.

The employment of an additional health visitor in this special field had other advantages, it was possible, for example, for one worker to spend more time in the office giving assistance and guidance to callers with problems, rather on the lines of a family bureau as envisaged in the proposed Children's Bill.

Homeless Families

Nine families only were admitted to Part III Accommodation. Three were evicted by private landlords for non-payment of rent and another said to be unsatisfactory tenants (although they owed no rent) because the seven children were considered undisciplined. One woman was deserted by her husband, who left her pregnant, penniless and homeless. The remaining four families were admitted because of marital disharmony, which resulted in the wife and children leaving home either voluntarily or due to ejection by the husband.

All nine families were subsequently re-housed in sub-standard property by the Housing Department.

There was excellent liaison with the Housing Department in relation to prevention of eviction, upon which much time and effort was spent by the Health Visitor.

Case Conference

Conferences were held fortnightly under the Chairmanship of the Deputy Medical Officer of Health.

Number of conferences held		21
Organisations and departments represented		20
Number of representatives attending		117
Total attendances made		301
Average attendances per session		16
Number of discussions held		154
Number of families discussed		*100
	*64	discussed once.
	24	,, twice.
	7	,, three times
	4	,, four ,,
	1	,, five ,,
Average number of cases discussed per session		7·3

Day Training Centre

This Centre continues to function at 6, Acton Square, where a group of mothers continues to benefit from group therapy. Two new members joined and two left, making a total of 11.

Mothers attend by personal invitation made by area Health Visitors after consultation with the Specialist Health Visitor. They may be backward, dependent, anxious, unhappily married, or unmarried and socially isolated. Lack of housekeeping skill is not the sole qualification—but rather loss of morale.

Perhaps in some cases boosting of morale is the only success the centre can claim, and failure to bring about any fundamental change must be accepted—especially when dealing with some inadequate personalities.

The improvement in the physical and emotional state of the children of these mothers is quite remarkable, and behaviour problems are dealt with by the auxiliary nurse in charge of the nursery, in conjunction with the Specialist Health Visitor and parents.

On the social side, an annual dinner for the mothers, plus a Christmas Party for the children, and a visit to the Pantomime was arranged and thoroughly enjoyed by all.

Staffing of the Centre remained unchanged.

Of all the families dealt with by the Section throughout the year :—

5 families moved out of Salford ;
5 ,, disintegrated ;
21 ,, were taken off the register as stabilised ;
234 ,, remained on the register and were carried over to 1963.

(*e*) Unmarried Mother and Her Child

In all, 129 mothers were dealt with during the year, 87 were new cases and 42 carried over from 1961.

Of the 87 new cases, 46 were expectant mothers, 27 of whom were single girls expecting a first child. In the remaining cases, 41 children had already been born. The number of first babies to single girls was again 27.

New cases were referred from the following sources :—

	As Expectant Mother	*After Confinement*
Health Visitors	5	15
Moral Welfare Agencies	4	5
General Practitioners	6	2
Midwives	3	1
Hospital Almoners	5	8
Mental Health Section	1	...
National Assistance Board	...	3
Factory Welfare Officer	1	...
N.S.P.C.C.	...	1
Probation Officer	2	...
Children's Department	2	...
Civic Welfare	1	...
Citizen's Advice Bureau	1	...
Own family	3	...
Own initiative	11	3
Councillor	1	...
Found whilst visiting	...	3
TOTALS	46	41

Hostel Accommodation

For some mothers hostel accommodation was sought as the most appropriate means of meeting the immediate problem. Arrangements were made through moral Welfare Organisations.

Application from Moral Welfare Agencies for financial assistance towards hostel fees were made and granted on behalf of 31 Salford mothers, seven of whom had been referred in the first instance by the Health Visitor. Many of the babies in these cases were adopted from the hostels.

General Problems

Girls were helped through other agencies where appropriate to obtain accommodation if required. Advice regarding maternity and other benefits,

including National Assistance, was given. Help was also obtained from the Children's Welfare Fund and other voluntary agencies to provide clothing, cots or pram, etc., in needy cases.

Where sufficient evidence was available, girls were advised regarding Affiliation Order procedure. Five girls were referred direct to the Court by the Health Visitor, four of whom were successful and three were referred to the National Assistance Board for assistance with their applications, two of whom were successful.

Help was also given regarding finding employment and means of care of the baby during mother's absence—priority was given to these girls in gaining Day Nursery places for the babies.

Work for the Unmarried Mother and her Child was carried out by a special health visitor, who collaborates with General Health Visitors and all other agencies who may be able to help. Office interviews numbered 46. Home visits were paid in the first instance by the special worker who referred appropriate subsequent visits to area health visitors. Unsatisfactory cases received special attention. During the year :—

Removed from Salford	26
Married	10
Babies adopted	14
Living with mothers	1
Living with mothers' family	25
Cohabiting	11
Baby died	4
Still-birth	1
Carried over to 1963	37
TOTAL	129

(*f*) Training of Students

The practical training of Student Health Visitors and training of Student Nurses in Social Aspects of Disease continued under the guidance of a special health visitor. The same health visitor also arranged in-service training of staff and dealt with the needs of members of outside organisations wishing to visit the section or learn about its activities.

Student Health Visitors

Full practical training of Student Health Visitors was given to all Student Health Visitors sponsored by this Authority.

Student Nurses

Junior and Senior Nursing Students, with some trained staff, were taught something of the social aspects of health and disease. Some were able to see former patients against the wider aspect of their home background and to learn of some of the problems and handicaps which could lead to a breakdown in health. They were able to see that many outside services are frequently necessary both before and after hospital admission and to appreciate some of the difficulties which major illness may create in a family. Discussion, questions and comments were encouraged. There was good co-operation from local authority staffs of all departments.

The following groups of students attended during the year :—

HOPE HOSPITAL
56 Junior Nurses in eight groups for one day each.
30 Senior Nurses in four groups for two days each.

SALFORD ROYAL HOSPITAL
14 Junior Nurses in four groups for three days each.
6 Senior Nurses in two groups for three days each.

ROYAL MANCHESTER CHILDREN'S HOSPITAL
25 Junior Students in four groups for three days each.

CRUMPSALL HOSPITAL
27 Senior Students in three groups for one day each.

MANCHESTER UNIVERSITY COMMUNITY NURSING COURSE
10 Students in two groups of four days each.

BOLTON AUXILIARY NURSES
5 Students and one Tutor in one group for half day.

SALFORD NURSERY NURSE TRAINING COLLEGE
30 Students in two groups of half day each.

There were in addition :—

SEDGELY PARK TEACHERS TRAINING COLLEGE
30 Students in two groups of half day each.

MANCHESTER UNIVERSITY COURSE—DIPLOMA IN CHILD HEALTH
2 Doctors attended for 20 visits of half day each.

Talks to outside organisations were given as follows :—

Mothers Clubs.
Darby and Joan Clubs.
Nursery Nurses.
High School staff and pupils.
Pre-Nursery Students.
Hairdressing Students.
Church groups.

In-Service Training

After qualification, former student health visitors remain for an appropriate period under guidance of the special health visitor responsible for practical training. Newly appointed Clinic Nurses also receive in-service training as many have had no previous experience outside hospital and need to learn not only their appropriate duties in public health nursing but approach to parents, teachers and the public health team in general.

Refresher Courses

Arrangements were made for health visitors to attend Refresher Courses as follows —

Mental Health and the Community—Springfield Hospital.
Family Health—Ashbourne Hall (Royal College of Nursing).
Health Education—Manchester Health Department.
General Refresher Course—Manchester Health Department.
Residential Course—Bedford College, London (two Health Visitors only).

Discussion Group

A Discussion Group was formed under the personal guidance of the Consultant Child Psychiatrist—Dr. Gage—to help health visitors to a better understanding of, and wider insight into, psychological problems affecting children. This group was formed in October with six or eight health visitors attending some twelve discussions—a different group of health visitors then began a similar series.

General Practitioners and Health Visitors

One family doctor holds a well-baby clinic, assisted by his wife, who is a qualified (non-practising) health visitor. The area health visitor attends this clinic in the absence of the doctor's wife, and is in close tough with the doctor in the normal course of his work.

In two cases, appropriate health visitors visit particular general practitioners at a fixed time each week for general discussion and referral of patients, in addition to making contact at any other time when circumstances warrant this.

All health visitors make a point of making contact with family doctors about families as the need arises. Many general practitioners get in touch with the health visitor by telephone—some send in pre-paid cards requesting the services of a health visitor.

An attempt was made during the year to arrange for a health visitor to work with, and from the surgery of, a general practitioner. No suitable applications were made in response to advertisements for a health visitor to undertake this work.

Clinic Service

All clinics—Infant Welfare—Elderly Persons—Immunisation—Child Psychiatry—were staffed by health visitors, clinic nurses and/or nursing auxiliaries as appropriate. Efforts were made to cut down regular routine weighing of children and to concentrate rather on individual consultation with the health visitor and health education. Group talks were given whenever possible.

Immunisation

Defaulters from clinics were referred to the health visiting section, and domiciliary immunisation offered in all cases needing triple antigen. All members of the health visiting section staff played a part in immunisation of children and adults, but clinic nurses were used for this work whenever possible. Over 90% of all injections for immunisation in clinics, homes and schools were given by nursing staff. A full report on immunisation is given elsewhere in this Report.

Mothers Clubs

Two evening clubs continued to function at Langworthy Centre and at Ordsall Clinic. During the year a new Club was opened at Kersal Centre. Members met fortnightly—with an average attendance of about 25. Activities included talks with an educational slant, *e.g.*, one speaker was a butcher, who spoke about the various cuts of meat, what to buy and how to cook

it ; another speaker gave a talk on a visit to Israel. Cookery demonstrations were arranged, including one on Christmas confectionery, by members of the club themselves. Visits to places of interest were also arranged. Health Visitors were responsible for the overall supervision of activities, but members themselves actually run these clubs.

Chiropody

The Old People's Chiropody Service in Salford has now become a well-known and well-established part of the Local Authority Health Service.

Since its inauguration, it has grown to nineteen clinical sessions per week and is giving chiropody treatment to over one hundred and fifty patients per working week.

Appointments are arranged by the chiropodist in the clinic as far as possible to suit the convenience of the patient, for example, to fit in with holidays and the various pensioners outings.

The term " chiropody treatment " is used as distinct from "pedicure" which has no place in a chiropody service which attempts to be both efficient and thorough. It is all too easy for chiropodists when faced with heavy case loads due to the pressure of a substantial waiting list for treatment, to allow the quality of their work to depreciate into the " cut and come again " variety or, as a former Minister of Health once put it, " pare and pad." A worthwhile chiropody service must not undertake simply the paring of corns and reducing of toenails but must consist first of all of a detailed examination of the feet for the purpose of defining any weaknesses in structure and function, the condition of the soft tissues, condition of the nails, any painful lesions present and any signs of impending trouble. After this, any local signs of systematic disease must be noted, and the condition and type of footwear must be taken into account before any short-term and long-term treatment can be attempted.

In previous reports emphasis has been placed on the dangers of even minor traumatic lesions on the ischæmic and neuropathic foot and the increased susceptibility to sepsis of the diabetic patient. Because of this it was thought to be advisable to supply all diabetics attending the Chiropody Clinics with a leaflet of simple instructions regarding the measures to be taken in the interest of foot hygiene and the modes of home treatment to avoid. (It is a fact that chiropodists, almost daily, come across septic lesions which have been produced by so-called " corn cures " sold indiscriminately over the chemist's counter). It was also thought to be expedient to add to the above list of the signs and symptoms of impending trouble for which the diabetic should be on the lookout, with the instructions to attend the clinic immediately should any of these symptoms appear. This was greatly appreciated by the patients who found it difficult to memorise all the verbal instructions of the chiropodist.

The year 1962 saw the opening of the new Kersal Health Centre which incorporated a chiropody clinic. This clinic proved so popular that within three months of opening a further weekly session had to be started.

The Ambulance Service has been of great assistance by carrying 763 patients to the clinics for treatment who could otherwise not have managed

to get there on foot, and the chiropodists have made 1,659 visits during the year to the homes of the bedridden and housebound so that they, too, may not be neglected in this very important section of the health and welfare services in Salford.

This service is an ever-increasing snowball in that few, if any, patients can ever be discharged. Once on the register, only death of a patient as a rule removes him.

Treatments given in 1962 numbered 7,222, compared with 4,149 in 1960. At the end of the year patients remaining on the register, to be carried over to 1963, numbered 2,227, against 1,389 at the same period in 1960, an increase of over 62% in two years.

Treatment Given :	Walking Cases		Sitting Cases		Totals		Grand Total
	Male	Female	Male	Female	Male	Female	
Langworthy Centre	440	1,820	98	665	538	2,485	3,023
Regent Clinic	214	1,085	...	...	214	1,085	1,299
Murray Street	98	642	...	...	98	642	740
Kersal	83	418	...	...	83	418	501
Clinic Attendances	835	3,965	98	665	933	4,630	5,563
Number treated at home ...	...	...	...	...	306	1,353	1,659
Grand Total of treatments given	...	...	...	...	1,239	5,983	7,222
1960					770	3,379	4,149

Clinic attendances were as follows :—

	Invited	*Attended*	
Langworthy	3,418	3,023	
Regent	1,520	1,299	
Murray Street	874	740	
Kersal	565	501	
TOTAL	6,377	5,563	= (87·235%)

NEW CLINIC SESSIONS

Kersal (new clinic) from 28th February ... ...Two sessions weekly.
Murray Street ... ... One additional session weekly.

TOTAL CLINIC SESSIONS HELD

	Day	*Evening*	*Total*
Langworthy	416	49	465
Regent	147	49	196
Murray Street	109	...	109
Kersal	72	...	72
TOTAL	744	98	842
1961	625	98	723

PATIENTS STILL UNDER CARE AT YEAR-END

(*a*)	Able to attend clinic unaided	1,600	(71·8%)
(*b*)	With transport (sitting car) provided	260	(11·67%)
(*c*)	Domiciliary cases	367	(16·48%)
	Total remaining on Register, 31st December, 1962	2,227	
	„ „ „ „ „ „ 1960	(1,389	

Statistics

A statistical summary of visits paid and clinics attended by all members of the Health Visitors Section, viz : health visitors, clinics, nurses and nursing auxiliaries, is given below :—

Health Visitors and Clinic Nurses

Type of Visits	*Access*	*No Access*
First visits—children 0—1 year	2,770	993
Total „ „ 0—1 „	11,396	2,509
Visits „ 1—2 years	4,183	577
„ „ 2—5 „	11,020	1,758
First visits to ante-natal mothers	326	23
Total „ „ „ „	450	31
Visits to tuberculous households	925	265
First visits—aged persons	1,242	122
Subsequent visits—aged persons	4,288	474
Mental health visits	62	13
Immunisation	3,799	1,612
Miscellaneous	4,501	917
TOTAL	41,870	7,548

Public Health Clinic Sessions

	Health Visitors	*Clinic Nurses*
Full sessions	2,269	503
Part „	234	19

Nursing Auxiliaries

(*a*) HOME VISITS

Bathing baby	4
Aged and infirm—bathing	1,278
„ „ „ foot hygiene	2,043
„ „ „ miscellaneous	950
Miscellaneous—general	109
TOTAL	4,384
No access	528
GRAND TOTAL	4,912

(*b*) CLINIC SESSIONS

Ante-Natal	39
Infant Welfare	304
Day Training Centre	286
Minor Ailments	1,126
Chiropody (schoolchildren)	622
Scabies	15
Eye Clinic	515
Medical examination	20
Camp and miscellaneous sessions	24
Cleansing (children cleansed, 44)	14
TOTAL	2,975

(*c*) School Sessions (in collaboration with health visitors).

Health survey	140
Vision testing	104
Hygiene inspection	168
School medical inspection	27
Short visits in schools	49
Immunisation in school	121
Total	609

(*d*) Syringe Service

Sessions spent	842

HOME NURSING SERVICE

District Nursing is a professional and highly personal service which brings comfort and nursing skills into the homes of many people. In fact, more people than ever before are likely to need the services of home nurses in the future arising from the changing pattern of community care outlined in the Ministry of Health's ten-year plan. This is certainly true of the Salford Home Nursing Service where efforts to improve the service to the patient with the ever expanding volume of work continue uninterrupted.

Expansion of Work

The last two years have seen a steady increase both in the number of patients and visits. This fact is well illustrated by the number of patients carried forward each year as follows :—

1st January, 1961	383
,, 1962	466
,, 1963	547

A more detailed comparison between the number of cases during the two years shows the tendency to increase even more clearly.

	1961	1962
Patients carried over from previous year	383	466
New patients	1,732	1,810
Total number patients nursed	2,115	2,275
Cases closed	1,649	1,729
Patients carried over to following year	466	547
Net increase	83	81

Comparison of the Total Number of Visits

1962	55,660
1961	49,415
Increase	6,245

This is a substantial increase, accounted for not only by the rise in the number of patients, but also by an increase in the number of visits per patient (24·4 in 1962, compared with 23 visits per patient in 1961). As more aged patients were nursed in 1962, one would expect a significant increase in the number of visits, for there is a tendency for elderly patients to stay longer on the books and to require more frequent visits than younger patients. The

improvement in the staffing position has also helped to push up the number of visits per patient ; obviously, when enough nurses are available it is possible to give every patient as many visits as required.

Sources of Referral—Comparison with 1961

In 1962 the number of new referrals was 1,810 compared with 1,732 patients in the previous year, an increase of 78 or nearly 5%. This is mainly due to an increase of 58 from family doctors. We are particularly glad that general practitioners are making more use of the Home Nursing Service and we would be happy to see a continuation of this trend.

Referrals from the Health Visiting Service have increased from 17 to 66. Most of these were sick old people referred by the Specialist Health Visitor for the Aged because they require more nursing care than could be given by Bathing Attendants.

The number of patients handed over by Midwives increased from 3 to 15.

Applications by patients' relatives have risen by 20, from 31 to 51. Many of these applications started as a request for some article of sick room equipment, such as a bed pan or mackintosh sheeting. In such cases the help and advice of a Home Nurse is offered to the patient or his relatives, particularly when the patient is reported to be incontinent and thus liable to bedsores. The family doctor is always informed.

Hospital referrals on the other hand have decreased by 61 (from 390 to 329). More than the whole of this reduction is accounted for by the fact that for the first three months of 1962 very few patients were referred for preparation for X-Ray investigation. Hospital referrals other than preparation for X-Ray investigation increased by 24 ; these consisted of post-operative treatments and other after care, as well as specialised treatments.

Age Groups

	Patients	*Visits*
0—5 years	74	590
5—15 ,, ...	24	365
15—64 ,, ...	1,005	20,733
65—74 ,, ...	582	15,504
Over 75 years	591	18,468

As in the previous years the number of old people nursed has again increased.

Whilst the number of old people nursed during the year has again risen over the previous year the proportion of the total number of patients has remained unaltered.

In 1961 there were 1,109 old people out of a total of 2,115 (52%).

In 1962 the number of old people, 1,173, compared with a total of 2,276 (just under 52%).

This fact is of some interest because in 1960 the percentage of old people was only 46%, in other words 1961 showed a 6% increase in the number of old people, but in 1962 the proportion of old people did not rise.

Comparison in the number of visits gives the same picture. Visits to old people rose from 30,613 in 1961 to 33,972 and the total number of visits rose from 49,415 to 55,660, but the percentage of visits to old people in the total number has declined from 62% to 61%. To put it the other way round the work for the younger age groups has increased in the same proportion as the work for the older age groups—in fact has risen slightly from 38% to 39%. This development is quite unexpected and most encouraging. In actual figures, visits to patients under 65 years rose from 18,802 to 21,688.

Statistics

Number of patients on books, 1st January, 1962	466
,, ,, new patients during 1962	1,810
TOTAL	2,276
Number of patients taken off the books in 1962	1,729
,, ,, patients remaining on the books, 31st December, 1962	547
TOTAL	2,276
Total visits during 1962	55,660

SOURCE OF CASES	1962	1961
Family doctors	1,349	1,291
Hospitals	329	390
Personal applications	51	31
Midwives	15	3
Health visitors	66	17
TOTALS	1,810	1,732

RESULTS OF NURSING CARE	
Patients recovered	765
,, transferred to hospital	348
,, died	258
,, preparation for diagnostic investigation	188
,, discontinued for other reasons	146
,, removed from the area	24
, remaining on books 31st December, 1962	547
TOTAL	2,276

CLASSIFICATION OF CASES AND VISITS	*Cases*	*Visits*
Medical	1,785	45,652
Surgical	238	7,293
Infectious diseases	6	42
Tuberculosis	26	2,224
Maternal complications	33	215
Preparation for diagnostic investigation	188	234
TOTALS	2,276	55,660

Case Histories from two different nurses are given below :—

(*a*) In February, 1962, a female patient aged 62 was referred by the family doctor for general nursing care following a cerebral thrombosis.

INITIAL VISIT, 23RD FEBRUARY, 1962.

Mrs. T. was living in a semi-detached two-bedroomed house with her daughter and son-in-law. She was found to be semi-comatosed T.100.2, Pulse 108, Respiration 26, Pulse fairly regular and of good volume, respiration slightly increased but otherwise normal. Patient very ill, and incontinent.

Patient made comfortable, with left arm supported on a pillow, cardboard box filled with books placed at foot of bed to keep weight of bedclothes off lower limbs. Daughter reassured and instructed not to disturb her mother unnecessarily.

Son-in-law asked to call at Home Nursing Department for mackintosh, air ring and ped pan.

24th February, 1962.

Mrs. T. regained consciousness T.100, P.98, R.24. Reported by daughter to be sleeping for long periods, able to take fluids. No movement in left leg and arm, no grip in left hand. Patient washed and made comfortable, pressure areas treated and mouth cleansed. On the evening visit the patient was again made comfortable.

25th March, 1962.

T.98, P.98, R.24. Patient feeling better and able to take semi-solids ; quite alert and speaking well. Some redness of pressure areas, daughter advised on changing position. General nursing care given ; passive leg and arm exercises commenced.

Son-in-law fixed rope to bottom end of bed so that patient could pull herself up and change position.

26th March, 1962, to 8th April, 1962.

Physical progress maintained, Mrs. T. now eating and sleeping well most times, but has periods of depression when she suffers from insomnia and complains of headaches. Some strains in family situation noted. Still unable to help herself much but very co-operative with the nurse ; Mrs. T. encouraged to sit on the edge of the bed for a short period each day and at the end of this period able to sit in armchair for a few minutes for bed making. Patient reassured during periods of depression that she is going to walk again in spite of her present fears. Mrs. T. able to wash herself with help of daughter. General nursing care continued as far as necessary.

8th April, 1962, to 29th April, 1962.

Mrs. T. now able to sit out of bed for longer periods. Bed pan discarded as soon as she was able to use the commode on loan from the Home Nursing Service. Other equipment lent included a light metal four-legged walking aid, so that walking exercises can now be started. Mrs. T. had now to learn walking all over again and needed much encouragement and emotional support from the nurse and her family. Fortunately, the patient was anxious to get back on her feet, was co-operative and made fairly good progress in walking. In this she was constantly encouraged and helped by her daughter's husband, who gave endless time to walking her round and supervising her exercises. He was very keen that his mother-in-law should re-establish her independence and not be a permanent burden to her daughter. Discussing these problems and their feelings with the nurse proved of great help to Mrs. T.'s daughter and her husband, and was an important factor in her rehabilitation.

Towards the end of the year Mrs. T. was admitted to hospital for physiotherapy and the fitting of supports and a more specialised walking aid ; she was discharged after one month. Throughtout this time the arm improved very little, but the patient learned to live with this disability.

Mrs. T. is now walking well with the aid of a stick, she is overjoyed at being able to do housework again and to walk upstairs, where she is once more sleeping.

(*b*) Charles L., aged 18, was discharged from hospital after ten months treatment following a motor cycle accident. This left him with paralysis of the right arm, shortening of right leg caused by a complicated fracture, severe muscle and tissue damage, leaving him with an open wound which was discharging and required daily dressings. The district nurse was asked by the hospital ward sister to attend.

After his long period in hospital this young patient looked pale and had lost a great deal of weight. His first few days at home caused much anxiety to his parents, he was not sleeping and refused all meals. Talking to Charles the nurse concluded he was missing the routine of the hospital ward and companionship of the patients who had been a great help and comfort to him. Being an only child he was now on his own with his parents. These problems were discussed with the parents to enable them to help their boy readjust to life at home. Advice on diet was also given.

The mother was asked to provide the necessary equipment from her household utensils for the nurse's daily visits and was instructed in the preparation and care of dressings. Several weeks of daily dressings were required before the wound healed completely.

Throughout his illness Charles had received reduced sickness benefit, as he had only worked for two years before his accident. To relieve financial hardship the patient was put in touch with the National Assistance Board who made weekly grants.

Realising that he was permanently disabled and would no longer be able to continue his previous work as an apprentice plumber, Charles was anxious to find other means of earning his own living and regaining independence. The lad received much encouragement from his nurse who at a later stage arranged an interview with the Disablement Resettlement Officer. Charles was put on the register of Disabled Persons and the D.R.O. has assured responsibility for his welfare and re-training, and sent him to a special rehabilitation unit. Charles is still at this centre studying accountancy, and it appears that he is adjusting himself to his disabilities and is making use of other talents. There is every hope that he will lead a useful and active life.

Sick Room Equipment

This service is now part of the Home Nursing Section. The range of articles of equipment available on loan to families has been greatly enlarged during the year, items added include lifting equipment for bedfast patients, walking aids, dunlopillo mattresses, commodes, wheel chairs, etc.

These articles have been much in demand and have proved specially useful to the nurses in the care of their patients—especially lifting hoists.

The following articles were issued on loan during 1962 :—

Bed pans	186
Air rings	113
Rubber sheeting	175
Back rests	109
Walking aids	17
Lifting poles	6
,, hoists	2
Wheel chairs	10
Commodes	22

Many articles of nursing equipment are not returned after they are no longer required. Much time is spent in writing and, in some cases, calling on the households concerned ; even these efforts are not always successful and a disquieting amount of nursing equipment is lost in this way at great cost to the Health Department. In spite of the cost of these replacements the sick-room equipment loans service is cheap in comparison with other expenditure and fully worth the money spent.

Where a nurse attends the patient an article such as a portable lifting pole or mobile back rest can make her work easier and more effective ; and in all cases the comfort of patients is increased.

District Nurse Training

In 1961 we were invited to participate in the practical training of students in the new Community Nursing Course at Manchester University. In this scheme general nursing, district nursing, and health visiting are integrated in one course, combined throughout with University studies.

It was decided to send students into the district nursing field for a four-week period of practical training following a one-week introductory period ; two of these students were placed with the Salford Home Nursing Service. During this time they gained practical experience of district nursing by having certain patients allocated to them under the supervision of an experienced district nurse. Demonstrations of various district nursing procedures and group discussions with the senior staff were a regular feature. Both students enjoyed their time in Salford and felt they had benefitted from their experience.

The students spent a further whole month in a rural area. Their district nurse training will be completed by a return to Salford for two weeks to revise and consolidate what they earned earlier and prepare for the examination of the Queen's Institute.

Three students took the normal district nurse training course and were successful in passing the examination for the Queen's Roll and National Certificate in District Nursing.

Home Nursing Staff

The improvement of the staffing position between the beginning and the end of 1962 is shown by the following figures :—

		1*st Jan.*, 1962		31*st Dec.*, 1962	
Queen's Nurses			6		7
State Registered Nurses :	Full-time	4	5	4	6
	Part-time	2		4	
State Enrolled Nurses :	Full-time	3	$3\frac{1}{2}$	5	$5\frac{1}{2}$
	Part-time	1		1	
Nursing Auxiliaries :	Full-time	1	2	3	$4\frac{1}{2}$
	Part-time	2		3	
			$16\frac{1}{2}$		23

New Appointments consisted of three Queen's Nurses, four State Registered Nurses and three part-time ; two Enrolled Nurses and two part-time ; two Nursing Auxiliaries and two part-time.

Resignations. Two Queen's Nurses, four State Registered Nurses and one part-time ; one part-time State Enrolled Nurse ; one part-time Auxiliary.

This considerable turnover of staff mostly tied up with the domestic circumstances of married members of staff : of the most stable group on the

staff, namely the Enrolled Nurses, four out of five full-time nurses are single women and the other is a widow.

Future Plans

Accommodation at the Murray Street Welfare Centre has been put at the disposal of the Home Nursing Service. As soon as the necessary alterations are completed it is hoped to make a start in the decentralisation of the Salford Home Nursing Service. The basic idea is for a nursing team to take responsibility for an area of the city, in this case the Broughton area consisting of St. Matthias ward, Albert Park ward, Mandley Park ward and parts of Kersal.

It is hoped that working from a local centre will cut down the nurses' travelling time, thus enabling them to give more time to their patients without undue strain. It will also facilitate easy contact with family doctors and other members of the health team working in the area, and promote the closest co-operation in the service of the patients and their families.

HOME HELP SERVICE

Aged and Chronic Sick

Restriction of revenue had an unfortunate effect during the exceptional weather conditions which commenced at the end of the calendar year and continued into 1963. Even though the cost per 1,000 of the population is higher than in any other County Borough in the North-West there were numerous cases given an inadequate allocation of help in order to alleviate distress in the greatest number of homes. Daily service was given in some instances, but where a sick or elderly person lives entirely alone help is also needed in the evenings and at week-end. Some of the home helps voluntarily visited householders at these periods and these demonstrations of neighbourly concern were appreciated by the recipients and the Home Help Organiser.

The majority of home helps are married women with families and most of their husbands work only a five-day week. Obviously it is very difficult to provide a service outside normal working hours, but a close acquaintance with the lives of sick and housebound persons continually emphasises this need. Much admirable visiting of the elderly takes place in the City, but often the visitor lives some distance away and cannot call very frequently. Neighbourly attention in the small tasks of replenishing the fire, giving an evening drink, and relieving the feeling of isolation would do much for the comfort of the patient. Salford fortunately still retains a considerable amount of community life in some areas, but re-housing must inevitably disturb this pattern. Some areas of the country have established " Good Neighbour " schemes and it seems that effort expended in this direction might be very worthwhile. The percentage of persons in the population over the retirement age is growing as younger people leave the district and a situation can easily arise where immediate neighbours are themselves elderly or frail. Sometimes people can be even more isolated in large blocks of flats than they were in the old streets of the town and it appears that the Health Department should sponsor some voluntary " Watchful Eye " scheme. Often it is only necessary for someone to notice that curtains are drawn and the light put on when it is dark, that the light is extinguished late at night, and that curtains are opened again in the morning. Relatives who live some distance away should ask a neighbour to undertake this duty, but often they are reluctant to recognise that such support is needed. The very existence of a high standard in the domiciliary services can prelude neighbours' action since it is often mistakenly assumed that the Health Department are aware of any illness or distress.

CASES FOR WHOM HELP WAS PROVIDED DURING THE LAST FOUR YEARS :—

	1959	1960	1961	1962
Maternity	70	59	54	56
Tuberculosis	9	11	8	5
Chronic sick, aged and infirm	1,382	1,428	1,530	1,687
Other cases	26	33	49	47
TOTALS	1,487	1,531	1,641	1,795

SOURCES OF APPLICATIONS (expressed in percentages) :—

Health Visitors	27·64
Self	16·82
General Practitioner	11·09
Relatives	10·43
Hospital Almoners	10·04
Friends	6·39
National Assistance Board	6·13
District Nurses	4·44
Welfare Officers	1·95
Mental Health Officers	1·82
Cripples Help Society	1·30
Midwives	1·04
Public Health Inspectors	·91

Special Family Cases

Home Helps attended homes to care for children in various distressing circumstances. The mother of two schoolboys committed suicide and service was given to enable the father to keep the home together. The mother of three young children between five months and six years was admitted to a psychiatric ward and a Home Help cared for the family during the mother's absence and upon her return. In another case the mother of five young children was helped during her sixth confinement and for a little time afterwards. In all these cases, and several similar ones, there were difficulties connected with inadequacy, poor budgeting, and often unco-operative and irresponsible fathers. Nevertheless, there are homes where one admires the tenacity and determination of the parents to do their utmost to provide a secure and happy background for the family in spite of illness of the mother. There is obviously a great deal of useful work which could be done amongst families suffering temporary disturbance because of sickness of mother, father or children.

Ordinary families all have their troubles from time to time and if one child is ill, at home or in hospital, the mother often has difficulty in dividing her time. Obviously a child in hospital can only be visited if someone cares for the other children, and now that the great importance to the sick child of mother's presence is recognised, the home help service should provide help for the remaining children. Unfortunately the availability of the service is not sufficiently appreciated and this is very evident in the figures of the number of school-children kept at home to perform domestic tasks. Also there are undoubtedly homes where the need for help is overshadowed by reluctance to admit a home help because the mother feels the home is too poor or unprepared for visits from a stranger.

Maternity Cases

Help supplied 20 hours and under weekly	37
Help supplied over 20 hours weekly	19

During the year, 56 maternity cases were served and it was pleasing to note that several had had service for previous babies also, thus proving that help was appreciated. Unfortunately not all mothers agreed to have "full-time" home help, and it is felt that service from morning until late afternoon is always much more satisfactory than reliance upon neighbours or visitors for the afternoon. The low number of maternity bookings is a matter of concern to doctors and midwives who must often work in a situation where the domestic management of a home during confinement of the mother is very far from adequate.

Night Sitting

During the year this service was resuscitated and will be used to provide relief for relatives who have been sitting with patients during the night ; to care for very ill patients awaiting hospital admission, or to give night attention to patients who are not expected to recover. Whilst it is not expected that great demands will be made for the service it is a much needed development.

Charges for Service

Summary of payment for service :—

	Free	*Part Cost*	*Full Cost*
Maternity	10	34	12
Tuberculosis	4	1	...
Chronic sick, aged and infirm	1,358	323	6
Other cases	12	32	3
TOTALS	1,384	390	21

Charges for the service were revised in October when changes were made in the Determination of Needs of the National Assistance Board, with the result that only 14% of the recipients were required to pay towards the cost of the service. Maximum charge remained at 4s. 4d. per hour, but only 21 cases were required to pay this amount. In cases of hardship for social or financial reasons charges were waived altogether.

The Home Help Service has an important role to play in future plans for hospital and health services, and if " care in the community " is to be truly effective expansion of the scope of service and increase in staff and management personnel will need to be considered.

Staff

The service has always had a considerable staff turnover and at the end of the year there were 241 Home Helps. Fifty-two of these had less than one year's service, whilst 26 had 10 years or over. The average age of Home Helps is quite high, 107 being between 25 years and 45 years, and 134 between 45 and 65 years. Two only are single, but there are 30 widows who generally work sufficient hours to supplement their pensions or widowed mothers' allowances to the limit allowed by the " earnings rule."

The recruitment to the service of younger women would prove advantageous and it may be that "pre-entry" training schemes would attract young women as full-time workers. Other countries employ young women from the age of 18 years on a career basis and often retain their service during marriage, once their children no longer require constant care. Recruitment of staff

presents no numerical difficulty as Salford appears to have large numbers of married women available for part-time work. Usually there is a waiting list of applicants but many apply and are found unsuitable for the work.

The administrative staff has remained at the same level of organiser, two social workers and two clerks. The ratio of administrative staff to numbers of cases and Home Helps is sufficient evidence of the difficulties which are experienced in giving adequate staff supervision and periodical visiting. The two social workers had a very strenuous year and it is obvious that a staff increase is urgently required.

Number of Home Helps who terminated employment during the year ...	92
Reasons for leaving were as follows :—	
Ill-health	34
Other employment	14
Domestic reasons	12
Employment terminated because of absence	11
Ceased paid employment	6
Found work unsuitable	5
Removed	3
Pregnancy	5
Retired	1
Dismissed	1
TOTAL	92

Of the above, 62 had completed under two years' service.

Training

The course of training predicted in the last report was established at the Salford Technical College with 16 students meeting once weekly for 24 sessions. The organiser received enthusiastic co-operation from the Education Department, the staff of the college, and officers of all Corporation Departments who participated. The students appreciated the opportunity to attend and the training course will continue as a permanent feature of the service.

MENTAL HEALTH SERVICE

Summary

The year 1962 has been a year of comparative stability and consolidation in the Salford Mental Health Service. Trends towards voluntary relationships with patients were accentuated. A shift in the balance and type of care given by hospital and community is seen to have taken place in the care of the mentally ill. Duration of stay in hospital is shorter and more social support is provided by the local authority mental health service. The change is ascribed to the altered social role of mental patients rather than to change in the course of the underlying disorders. A similar increase in community care has taken place in mental subnormality.

The after-care of patients discharged from hospital has become more important in this situation. Care in this phase of illness is better than before, but not yet good enough. Results suggest that support given by social workers after discharge has an influence for the good on outcome.

Problems in the structure of psychiatric services are outlined, as they relate to the medical officer of mental health, to psychotherapeutic day centres, and to institutions for the mentally subnormal. Proposals are made for a Mental Health Centre in Salford and for an experiment which would decentralise the regional system of hospital care for the subnormal and localise it in the community.

* * * * *

The Annual Reports of the Salford Mental Health Service since 1957 have documented a process of continuous development. The hospitals, local health authority and general practitioners have attained good relationships with each other in their work. A psychiatrist (Dr. H. L. Freeman) now holds appointments in the mental hospital, in the general hospital psychiatric units in Salford and in the local authority mental health service ; in these capacities he makes many domiciliary assessments of patients together with mental welfare officers. By virtue of these appointments he has direct access to the whole range of facilities available in the area. Several facilities have been set up for the assistance of psychiatric patients outside hospitals and staff have been found to work in them. There was no pool of experienced workers to draw on ; wardens were needed for hostels, and supervisors and special teachers for training centres for subnormal individuals. Others had to be brought into the service, and trained to carry out the social work necessary for the support of patients in the community. Systematic methods of recording by mental welfare officers enabled a continuous statistical review of the operation of the services to be maintained. At the same time, purposeful record keeping has enabled us to undertake the examination of the precise dimensions of mental disorder in Salford, its distribution in different social groups, its diagnostic types, and the routes by which it breaks the surface of anonymity in the population and comes into treatment.

This position of defined goals and more rational organisation had been achieved by the end of 1961. Moreover, for the first time in several years the service had almost a full complement of staff, and a senior officer whose chief function was administrative and executive had been appointed and provided with a clerical staff to help him. As a result, 1962 could be a year of comparative stability and consolidation.

OPERATION OF THE SERVICE

Social Work

For two years now the Mental Health Act (1959) has been in full effect, and for a year before that Salford psychiatric services had been acting as far as possible in accordance with its provisions. Trends we have previously noted persisted and were accentuated, and some fresh trends became apparent. The mode of work of mental welfare officers continued the trend away from legal and formal relationships and towards voluntary and professional relationships.

In relationships based on legal authority the interests of others, whether society at large, neighbourhood, or family members, are usually given priority over those of the patient. Legal relationships are disciplinary or minatory, custodial or punitive. In typical professional relationships, the interests of the patient are primary and their intent is therapeutic or supportive. Deviation from expected behaviour is tolerated and is interpreted, as far as can be, as a problem for which the professional is being asked for help and should tender it.

In line with a growing professionalism, two of the mental welfare officers have become qualified psychiatric social workers ; one of these (Mr. G. Mountney) returned from training to take up the post of social work supervisor. Three others have had some university training in social studies. The trend towards professional social work is reflected in the marked decline in the proportion of compulsory admissions to mental hospitals compared with voluntary admissions. (See Table I and Appendices II and Va). This affects all patients and is not confined to any age or sex or diagnostic group, although it is most marked among those who come into contact with a psychiatric agency for the first time (inceptors).

Both therapeutic attitudes and voluntary admissions are facilitated in Salford by the improved co-ordination and continuity of services. These allow more or less free selection of the appropriate agency for the patient and the hospital is not a last resort. Moreover, the Mental Health Act (1959) reduces the legal apparatus of admissions to a minimum, and admission is therefore a much less formidable business.

TABLE I

	1957	1958	1959	1960	1961	1962
Compulsory	193	172	119	147	132	78
Voluntary	94	100	152	144	133	152
TOTAL	287	272	271	291	265	230

The extension of social work is further reflected in the steady increase in the number of referred patients who are given support at home and in the reduction of the number admitted from the mental health service. In an increasing proportion, this care is given in consultation with a psychiatrist through out-patient attendances or domiciliary visits. In Appendices II and V

the category of patients given home support is bracketed together with those cared for by the family doctor. In some cases this collaboration is presumed rather than real. In many other cases the conjunction is more meaningful. Thus, in 1962, three of the 69 practitioners made less than one referral per doctor in the practice and 37 made eight or more referrals. Four years previously, in 1958, 24 of the 69 doctors made less than one referral per doctor in the practice, and only three made eight or more (see Appendix VI).

The statistics also indicate a distinct change in the sequence of events for patients referred by general practitioners. In 1959, 64% of referrals by general practitioners ended in admission to hospital, but the proportion of admissions in 1962 had declined to only 30% (Appendix II). At the same time there was a rise during 1962 in the number of admissions arranged directly by general practitioners themselves. The latter change was promoted in part by the preference of some members of the mental hospital staff and not by the mental health service.

An indirect result has been further to shift the emphasis of the work of the mental health service from emergency calls and admission procedures to supportive social work. Thus, although practitioners made more direct admissions to the mental hospitals, they referred a larger number of cases to the mental health service. Our evidence shows that they are increasingly conscious of the help to be obtained from social workers and from the institutions of the mental health service.

Hospital and Community

The altered outcome of referrals from general practitioners was only one aspect of a more general phenomenon. The care which a mental patient receives from each branch of the health service has altered both in its nature and in the balance between the branches.

The length of stay of patients discharged from the main mental hospital for Salford has shortened : 70% of patients were discharged within two months in 1962 compared with about 50% discharged within two months in the previous three years (Appendix VII).

This is in accord with trends reported elsewhere in England. But in Salford there has been no compensatory rise in the number of admissions to mental hospital, taking all sources together. A small percentage of patients with mental illness are admitted to psychiatric units in general hospitals (Appendix VIII) and these units have probably absorbed some of the in-patients diverted from the main mental hospital. The out-patient clinics of the units in Salford itself are serving rather more Salford patients than previously.

A great part of the burden of care for patients not fully restored to health is deflected from the hospital on to families. The local authority mental health service can assist them in this, and we can assume that patients and families are making use of its facilities from the increased volume of work in general and of after-care in particular (see below). The proportion of referrals dealt with by admission is smaller and a larger proportion is given support outside hospital. Although there has been a gradual increase in the number of inceptors referred to the mental health service, shorter hospital

stay is perhaps mirrored in the sharper increase in repeat referrals during the calendar year (Appendix X). The amount of work done on each referral, as measured by the number of visits, while it has risen, is not great in view of the number of available mental welfare officers. Unfortunately, we have no measure of the duration and intensity of visits, which may well more than compensate for this.

Thus, patients not admitted to hospital are almost all candidates for social work of an intensity greater than mental welfare officers operating a legal role have been accustomed to give. For instance, in 1957, no action was taken in 19% of all referrals ; five years later, in 1962, no action was taken in only 4%. Responsibility for giving some kind of help is rarely evaded. Many " dead-end cases," who can expect little support or treatment from any other source, are taken on by the local authority service.

The change in the type of care given is not due to altered selection of patients who come into the ægis of the mental health service. The diagnostic categories of those patients admitted to hospital from the mental health service and of those patients kept in the community remain much the same.

The increased volume of community care is not confined to mental illness, but also includes subnormality, although changes are slower in this field. Many more subnormal patients than previously are receiving care in day centres and in hostels, although changes in the hospital population are relatively slight and slow (Appendices XIV, XV and XVII).

The effect of community services in the care of the subnormal was illustrated by an analysis made by Dr. Joyce Leeson in her report to the Manchester Regional Hospital Board, which shows that the demand for hospital beds for the subnormal in this hospital region is inversely related to the number of places available in training centres. Oldham, Wigan and Salford had at that time the lowest demand for hospital beds and the highest proportion of training centre places per head of population in the region.

Hospital admission is now less threatening and formidable for subnormal as well as mentally ill patients and here, too, need not be a last resort leading to long-term confinement. Hospitals for the mentally subnormal are therefore used more readily than in the past by the community mental health services.

With this growing exchange of services and views between the workers in hospital and community a situation more favourable to effective management is coming about. Co-ordination of services eliminates the misleading question of " hospital or community " and permits the best use to be made of both. The mental hospital can then be an agency, like newer psychiatric agencies, which not only serves the community but interacts with it.

A THEORY OF COMMUNITY CARE

One may conclude that hospital treatment for Salford patients is shorter and that mental patients are being maintained in the community for longer periods. There is no evidence to indicate that this could be because their mental disorder is cured. Treatment with drugs cannot do more than reduce the intensity and duration of some acute episodes of mental illness, so that patients can be discharged from hospital sooner.

The change in the type of care can be ascribed to the altered social role of mental patients rather than to any change in their underlying disease. This has to do with the current dominance of the medical interpretation of mental disorder ; thus the Mental Health Act of 1959 framed the laws relating to the management of mental disorder on the medical model. In other words patients are referred to our psychiatric agencies as sick persons, with the expectation that they will receive medical treatment and may recover.

Mental illness, and the functional psychoses in particular, frequently have a chronic fluctuating course punctuated by peak periods of acute activity. It is in the acute episodes that patients now ordinarily gain admission to hospital. We do not know whether these arise de novo or are precipitated by external events and demands, or whether both forms occur. In phases of remission and in less severe forms of mental illness, however, the social position and roles of the patient, in the family, at work, and in other forms of association are important factors in his performance, and in his continuing survival out of hospital.

Yet patients who are thus maintained out of hospital often are not free of symptoms, particularly those who suffer from schizophrenia. This emphasises the relative independence of the patient's social performance from the underlying pathological process. We are not yet able radically to influence many psychiatric illnesses by treatment, but we can influence the ways in which they are made manifest in conduct and behaviour. We know that the patient's performance of social roles is affected, if not determined, by the expectation of others, by the degree of tolerance with which others view his deviant behaviour, by the hostility or sympathy which he may expect in his social relationships, and by the composition of the household in which he lives. These factors act in devious ways, and not always in the direction one might expect.

Recognition of these forces provides opportunities which can be exploited by a community mental health service. Through social workers, relationships and attitudes can be influenced. Through institutions for community care situations can be altered. In the remission between acute episodes, many patients now remain in the community and fulfil at least some of their social obligations. Formerly, many of these patients would have remained in mental hospitals during periods of remission. In the mental hospital responses imposed on patients by its structure and roles have often appeared aberrant in the eyes of hospital staff. Such responses have been difficult to dissociate from the symptoms of mental illness, and have therefore favoured the prolonged stay of patients in hospital.

Likewise, more normal responses can be evoked by other situations. Much of the work of the mental health service is therefore designed to provide situations in which relatively normal social roles can be resumed or learned and maintained by patients. Essentially this is the aim of work in residential hostels, social and industrial training centres, and the home, with the social worker as executive agent.

Considered in these terms, admission to hospital is one form of situational change, a situational shock which forces the patient to revise or at least review his perception of himself and the order of his relations with others. Responses to this shock are various, but must be taken into account together with other treatments in assessing the effects of hospital admission. In addition, admission

can relieve the pressure of acute domestic tension, built up in the interaction between the ill patient and his family, and allows a period for reorientation of the family as well as the patient during his absence.

The pattern of care now evident varies according to the previous history of the patient. Of patients referred to the mental health service in 1962 who had come into contact with a psychiatric agency for the first time (inceptors) only 30% were admitted to hospital and of these only one-fifth were admitted compulsorily. Of patients with more than one previous admission more than 50% were again admitted on referral, and two-fifths of these were compulsory admissions (Appendix V). This result possibly reflects more than the intractable nature of chronic psychiatric illness. It may be that the patient repeatedly referred has acquired both resistant attitudes to psychiatric agencies from his past experience (in the context of a different set of laws), and a reputation among his kin and in the agencies which is conducive to admissions. If so, the outlook for the future of present-day inceptors may be brighter than would appear from the current experience of those with repeated admissions. Research would enable us to attempt predictions on this score.

After-care and Follow-up

These observations emphasise the importance of continuing support for patients with mental illness. Long-term confinement in mental hospitals in itself provides total support. Now that stay in hospital is relatively short little provision has been made for the transition from hospital to community. In many instances chronic mental disorder is being treated almost as an acute disease and the necessity for adequate and continuing arrangements on the discharge of patients is not always recognised. The cause of failures to recognise this need on the part of persons familiar with the pathology of mental disorder can only be understood in terms of the sociology of institutions (see Annual Report, 1961). In the past, public health has dealt successfully with the similar problem of tuberculosis, experience which largely lies unused in after-care.

In Salford arrangements are in hand to improve care for patients on leaving mental hospitals. This can be done only by efficient co-ordination between hospital, local health authority and general practice. The hospital has shown itself ready to accept patients as each crisis arises and then return them to the community, but patients and families need more preparation for the transitional experience of discharge. We need to be sensitive to the strain of the complicated interaction between mental patients and their families. Mental welfare officers can help in management by assessing the points of strain. The focus of their work is therefore slowly being switched to continuous support and follow-up of patients. In this they need the collaboration of general practitioners who are aware of the needs of psychiatric patients in the community.

An effective plan to provide support for patients immediately on discharge from mental hospital has proved difficult to devise. During the years 1956 to 1959 a routine notification was made to the mental health service of all patients discharged from mental hospital. This routine was discontinued at the beginning of 1960 as ineffective. The notification was perfunctory and arrived up to three weeks after discharge. Mental welfare officers found it difficult and unrewarding to resume relationships with patients who had already lived through the first shock of return.

During 1960, the hospital notified only those patients considered by the hospital psychiatrist to require the help of a mental welfare officer and willing to receive it. A sample check over a three-month period then showed that of 52 consecutive discharges only four were notified to the mental health service, although within three months, 20 of the remaining 48 were referred from other sources. This situation was much improved by the appointment of a psychiatrist with a definite assignment in the community mental health service. He has worked with social workers during the process of referral and screening leading to admission, and at the same time has tried to give the necessary feedback to the mental health service through case-reports on the patient's discharge. In 1962 we found that of 60 consecutive discharges of Salford patients case-reports were sent within one week on more than half (33). About half the omissions were due to failures in office routine. Two-thirds (21) of the patients reported on within one week were visited by mental welfare officers within one month of discharge from hospital.

Outcome, as judged only by readmission, seems to have been influenced by these visits. Among the 21 patients notified to the mental health service within one week of discharge and visited within one month, only three were readmitted within six months. Among the 12 notified but not visited within one month four were readmitted within six months. Among the 27 patients not notified on discharge to the mental health service 10 were readmitted within six months. Ten of the 27 had been visited within one month of discharge by virtue of their referral from some other source and of these 10 five were readmitted. Such referrals are usually made when all is not going well, and thus a high rate of readmission can be expected in this group.

The results show a tendency to a favourable outcome in patients notified shortly after discharge and then visited, although numbers are small and do not reach statistical significance.

We have taken into account certain factors which might have biased the results, such as age, sex and previous admission. For instance, patients with a tendency to a favourable outcome might have been selected for notification and visiting. From our data, and on commonsense grounds, such selection seems unlikely although some of the most difficult patients might not have been visited because the outlook for them appeared to be hopeless.

Clearly discharge procedures and continuity of care must be further improved. To this end mental welfare officers have been given access to patients in psychiatric hospital wards, although as yet they have not made much use of it. They can use this access to obtain the information they need to keep contact with patients and to prepare families for the patient's return.

One-third of patients notified at discharge to the mental health service by means of a case-report were not visited, and the outcome in these was very poor. This poor prospect might indeed have provided a reason for not visiting, as noted above. Nevertheless, the criteria which mental welfare officers use for selecting patients who should be visited after discharge need careful review, no less than the criteria used in discharging patients from hospital. The special needs and poor outcome in certain groups, such as the aged and those with previous admissions, must be taken into account. An important step towards this would be consultation before the discharge of the patient between psychiatrist, hospital social worker, and mental welfare officer in order to increase the exchange of information. At such a meeting,

long sought after by the local authority service, the now independent procedures of selecting patients for discharge and of selecting them for follow-up visits would be brought together and all relevant and available information would be to hand in making decisions. One factor which has slowed progress in achieving this is the serious lack, in the mental hospital, not of consultants, but of junior medical staff. (This is not to say that the consultant psychiatrist who deals with the bulk of Salford cases is not heavily pressed).

In order to build up a stock of knowledge on which to act in the best interests of patients and families more research should be devoted to the outcome of alternative ways of managing mental illness. In Salford progress has been made in the phase of community and pre-hospital care. Less is done after the patient is discharged from hospital ; the work begun before admission should be continued during and after the hospital stay.

Nor should we assume that all is well in the follow-up of those who are not admitted to hospital. Mental welfare officers have pressing duties in admitting patients, and are required to devote a good deal of time to the collection and recording of standard information. These various activities are not always easily reconciled and the less pressing work of the follow-up tends to be sacrificed. This is apparent in the reduced number of visits made to the mentally subnormal, who require long-term follow-up. We hope to diminish this problem in the coming year by developing partnerships between pairs of social workers.

STRUCTURE OF PSYCHIATRIC SERVICES

The shift in the burden of care, and the terms in which we have discussed admission and follow-up procedures, reflect improvements in the co-ordination of the services which have taken place in Salford. Problems of structure, authority and jurisdiction remain which have not been fully confronted, and which could give rise to difficulties in the future in this and other localities.

Medical Officer of Mental Health

The office of medical officer of mental health presents one such problem. The province of orthodox psychiatry is the care of individual patients, but the superintendent of a mental hospital, who is a psychiatrist, has also had to be a medical administrator. The province of public health, on the other hand, is the health of the community, including mental health, and incumbent on the medical officer of health is the administration of health services and their co-ordination. In the field of mental health and the administration of psychiatric services, therefore, an overlap of interest is likely to occur between psychiatrists and medical officers of health.

The well-trained medical officer of health brings to his work the skills of a medical administrator, including epidemiology and medical sociology. These enable him to measure the extent of disease and sickness and the need of services, to evaluate services and to analyse the structure and function of organisations for medical care. He is equipped and trained to see these problems as a whole, in terms of groups and not of individuals. But he is handicapped in the work of administration by his limited jurisdiction, which is confined to prevention and after-care within the services of the local health authority. He has no formal position in mental hospitals and out-patients clinics nor in connection with general practice.

By contrast, the psychiatrist in charge of a mental hospital has administrative duties in community mental health thrust upon him, although his training and outlook are nearly always focused on the individual, only sometimes on the small group, and seldom on the community outside the hospital.

Responsibilities in developing local services are not formally laid down. The balance of responsibility is partly determined by the local tradition and the state of development of each branch of the National Health Service, and by the activity and quality of the incumbents of relevant offices in hospital and local authority. Given the co-operation of participating agencies, the medical officer of health can carry out the function of measurement and evaluation, and he can also co-ordinate his own services. Unless the local health authority is prepared to pay for and support a strong community service, however, his influence in the area must remain limited, for he lacks bargaining counters, and the head of pressure towards compromise must be low. In Salford the local health authority has been generous in respect of services, with the result that there has been pressure towards co-ordination, and a degree of integration of hospital and community work.

Experience suggests that administrators who are not fully committed to total institutions such as mental hospitals are more likely to prosecute a vigorous policy of development of outward-looking services designed to support mental patients in the community, or to restore them to places in everyday life. Exceptions may occur, but the effective development of community services seems to require an officer with direct responsiblity to the local health authority for such work, whatever his other offices may be.

The question then arises as to what services the local health authority and the hospital authorities ought each to give. In Salford the local health authority offers social work, hostels, psychotherapeutic clubs, and day centres for many grades of patients, from severely subnormal children with physical handicaps to adults recovering from mental illness. These institutions serve manifold functions ; education to realise the potential development of subnormal children, socialisation, and training to cope with domestic activities and social situations, training in productive work and resettlement after stay in hospital (c.f. reports on Special Care Unit, Stepping Stones Club, and Cleveland Day Centre ; Appendices XIX, XX and XXI). The obligation of the local authority to do work of this kind is not in dispute, although it has not often been done and although hospitals have sometimes undertaken it.

In the two fields of *psychotherapeutic day centres* and of *institutions for subnormal patients* the resolution of function between local authority and hospital authority is less clear.

Day Centres

Day Centres run by local authorities can provide more than a minding service. The centre can be a frame for learning or relearning appropriate modes of social behaviour and restoring the perception of self in society, and it can be a training ground for acquiring the regular habits and some of the skills needed at work and in the home. Day hospitals run by hospital committees can provide, for patients who are able satisfactorily to reside in their own homes, all the facilities enjoyed by in-patients, such as treatment by drugs and by electro-convulsive therapy, diagnostic tests, etc.

Methods such as group therapy or individual psychotherapy require no technical equipment, however, and can be carried out in any suitable room, not necessarily in a hospital. Thus the distinction is less easily made as to the most suitable milieu for carrying out these types of treatment. The allocation of patients to group psychotherapy in a day hospital, and to group counselling in a day centre, asks for nice criteria of selection which are not self-evident.

The best solution in our view would be to combine such services in a single unit sited wherever suitable premises can be obtained and administered by hospital authority or local health authority through agreement between them. A mental health centre which thus brought services into effective combination would be a valuable innovation, and in Salford is desired by the local health authority.

Hospital premises for a day hospital will not be available in Salford for a considerable time. Physical treatments and technical investigations might therefore be separated from those aspects of group work which can be undertaken by the local authority mental health service. The service has a fund of experience in such work, and although it lacks suitable premises, it is seeking to provide them. In an interim plan the Regional Hospital Board could contribute sessions by psychiatrists, and they would direct the therapeutic activity. A precedent exists in the weekly therapeutic sessions undertaken from the beginnings of the Cleveland psychotherapeutic day centre for women by Dr. R. A. Blair, and since continued by Dr. Freeman. For the present no more is required from the hospital authorities than to allocate the time of psychiatrists (see Dr. Freeman's report, Appendix XXI).

Institutions for Mentally Subnormal Patients.

There has been less awareness among workers in mental subnormality than among those in mental illness that the pattern of residential care inherited from the early years of this century is outmoded. The concept of medical care for subnormal persons in large isolated mental deficiency hospitals has not been subjected to the same attack as care for the mentally ill in large mental hospitals. The Mental Health Act (1959) can be a charter for the mentally subnormal as much as for the mentally ill, but vigorous action is needed to give it effect. The discussion which follows owes much to exchanges with Dr. J. Tizard of the M.R.C. Social Psychiatry Research Unit, and to the work of Drs. A. Kushlick, Joyce Leeson and Zena Stein in this department.

Severe Subnormality

The care of patients within each grade of mental subnormality must be viewed through the life cycle. The birth and rearing of a subnormal child in a family often causes or exacerbates family tension, and the child may easily become a chronic focus of disturbance between spouses. The tension in family relations can be much relieved by early diagnosis and by careful and continuing counselling. This requires teamwork on the part of the pædiatrician, general practitioner and, not least, health visitor or social worker. In Salford the increasing number of early notifications in the youngest age group indicates progress in this work (see Appendix XII). These notifications bring to bear the work of the whole team.

A number of young children suffering from the severe grades of subnormality can benefit in infancy from attendance at a day nursery where they are stimulated by contact with normal children. Later their retardation becomes so marked as to raise difficulties in play, and they then do well in junior and adult day centres which try to make use of a scientific understanding of learning processes. At the upper end of the scale of severe subnormality, adult patients are capable of regular routine work of simple type, and a number are so engaged in Salford in industrial training centres. Some have even held jobs in open industry. Others can learn to read and to reckon, as our remedial teacher (Mrs. I. Hulme) has shown.

Special problems among these children arise with physical handicaps or behaviour disturbances of severe degree. Such children have made good progress in a special care unit sited in one of our junior training centres (see Dr. Wiseman's report, Appendix XIX), but we have not yet faced the problems that are likely to arise if they survive to adulthood. They raise the question of residential care.

Residential care for the severely subnormal, in an urban area, may be called for in three main circumstances :—

(1) Among children with severe physical handicaps, the technical difficulties of handling the growing child at home may eventually make residential care necessary. There seems little reason why this should not be given in local pædiatric and chronic hospitals. One child now accommodated in a local children's ward attends daily at the special care unit run by the mental health service. Perhaps this sequence could be the basis for a system of care ; the ward would become in effect a night hospital for chronic incapacitated patients.

(2) More difficult problems arise among subnormal children with behaviour disturbances, whether these are organic in origin or even more so when they are a consequence of disturbed family relations. In these cases, family tension and the harassment of uncontrolled behaviour can also lead eventually to residential care. We hope in the future to study the relationship between family emotional crisis and the demand for hospital admission. The best type of residential care would probably be in small units, approximating the prescribed ideal for normal children taken into care. Research has shown that in small units the potential for speech, intelligence and social behaviour is more fully realised.

(3) When parental and other support from kin becomes ineffective, owing to the natural development of the family cycle, transfer to an institution must take place. In our experience, institutions are best tolerated and accepted by patients and families if the transfer is made to an already familiar local environment. Short stays in local hostels can promote familiarity, and at the same time they help to relieve the strain caused by the permanent dependence of the subnormal person, and by the aging of the whole family.

High Grade Subnormality

The problems of subnormal patients of high grade generally become manifest at school when backwardness draws attention to them. According to results in Salford and elsewhere teaching in special groups gives the best results. This can be in special schools or in day centres, depending on

intelligence level. As adults these subnormal persons can learn to do productive work in the sheltered environment of an industrial centre, and many will later attain independence by earning a wage. (See Appendix XVI). The highest grades of subnormal patients thrive best in a sheltered environment at least until their twenties ; this postpones the plunge into independent adulthood.

There is much to suggest that a main need for patients of this type is time to grow and mature. In patients without brain disorder intellectual growth, retarded in childhood, continues into the late twenties ; from indirect evidence we would assume that they are retarded in physical growth ; and on clinical appraisal we have found them to be emotionally immature in reconciling their fantasies and aspirations with reality. But in later life most of these persons regarded as high grade subnormals at school cannot be distinguished from their neighbours.

The number of notifications of high grade patients, which before the Mental Health Act (1959) was concentrated in the 15–19 age group, has been much reduced (Appendix XII). In the light of our analysis, we need not be concerned about this provided those who are vulnerable and lack family support continue to be notified and thus receive the help of appropriate agencies.

The need for *residential care* among high grade patients arises when there is no effective support from kin, or occasionally when family tension arising from disturbed behaviour must be relieved.

The common sequence of events leading to admission to hospital of patients of the highest grade has been deprivation of family care at an early age (the dysmorphic family) followed by a series of acts which transgress the norms of society, or the norms of those in charge of them. Boys are most often classed as delinquent, girls as promiscuous. The hospital carries out the dual functions of substituting for their homes and keeping them under restraint ; it may also encourage the learning of useful skills. It cannot remedy the main deficiency in these cases, which is the normal process of socialisation provided by intact families with enduring relationships. The hospital is prevented from doing this by virtue of its organisational form.

In Salford, hostels have served as substitute homes for these patients, although not without difficulty (see Annual Reports, 1960–1961). Here, too, socialisation is not ideal, although closer to the norm. We have not been able to dispense with the hospital as a backstop when the tolerance of hostel or wider community has been exceeded. Frequently difficulties arise in patients who have long been institutionalised. They have learned the rules and how to manipulate the hospital system. But their learning is inappropriate to living in small groups and in open society. In dealing with such patients in hostels a great deal depends on the quality and skill of the hostel staff. Further experiment with smaller groups and with fostering is indicated.

Decentralised Care

Salford, and some other county boroughs in the north-west region, provide a good ground for experiment with a decentralised system of day and residential care for the subnormal. The borough has well-developed institutions for the care of such patients during the day, and has already made some headway with hostels for residential care (Appendix XVII).

In a combined project with the Regional Hospital Board, local services could cope with a much greater proportion of subnormal patients. The advantages for the patient would be the maintenance of a more normal social environment not entirely removed from familiar environs, family and friends, and the possibility of continuing in or obtaining work. These are not negligible benefits ; they undoubtedly enrich the lives of the patients and frequently add meaning to the lives of patients' families.

At the present moment 271 patients are in hospitals for the subnormal (41 low grade, 141 medium grade, 89 high grade). For all grades of subnormal patients who lack effective kin, either because they are not available, or because they do not have the resources to care for the patient, a fundamental need is the maintenance of enduring personal relationships. They constitute a large number of patients now placed in institutions. Many of these could gradually be transferred to hostels or small homes ; concurrently, day centres would need to be opened to provide for their re-training.

The project might well begin with small-scale experiments with foster-care and with family-type small groups. Housemothers could care for one, two or three patients in ordinary houses in the city. In suitable cases these houses might be the existing homes of the housemothers. In complex industrial societies, however rich, a " fair deal " for permanently dependent persons has proved difficult to provide ; good results in this project would go some way towards a fair deal for the mentally subnormal.

In the light of this discussion further development in the local community services, both for the subnormal and for the mentally ill, can be expected to bring fresh problems of structure and jurisdiction. There is reason to hope that solutions will not be particularly difficult in a region noted for the willingness of the hospital authorities to experiment with new kinds of psychiatric services.

APPENDIX I

MENTAL ILLNESS

Sources of Referral to Salford Mental Health Service (Percentage of Total Notifications)

Agency	Males				Females				Total			
	1959	1960	1961	1962	1959	1960	1961	1962	1959	1960	1961	1962
General Practice	45	46	47	53	45	53	53	51	45	52	51	53
Health / Welfare / Voluntary Organisation	5	5	5	2	11	9	10	4	11	6	8	3
Police / N.S.P.C.C.	13	12	6	4	4	3	5	3	4	6	5	3
Hospital Psychiatrist	8	9	12	13	10	10	12	19	9	10	12	16
General Hospital	6	3	7	3	5	5	5	3	5	5	6	3
Relatives	17	14	14	19	14	9	9	14	15	11	11	16
Other	5	11	9	5	11	11	7	6	11	11	8	5
	100	100	100	100	100	100	100	100	100	100	100	100
Total Number	193	248	215	241	310	339	340	348	503	587	555	589

APPENDIX II A

NOTIFICATIONS OF FEMALE PATIENTS REFERRED FOR MENTAL ILLNESS TO SALFORD MENTAL HEALTH SERVICE IN 1962
BY SOURCE OF REFERRAL AND DISPOSAL (PERCENTAGES)

Disposal	Source of Referral								
	G.P.	Health/ Welfare/ Voluntary Organisation	Police/ N.S.P.C.C.	Hospital Psychiatrist	General Hospital	Relatives	Other	Total Number	Total %
Compulsory Admission	15	...	36	3	...	16	14	43	12
Voluntary Admission	29	7	9	12	40	20	19	81	23
Psychiatric O.P. or Domiciliary Visit...	27	7	9	13	10	16	14	73	21
Home Support (and G.P.)	23	53	45	59	40	34	48	120	35
Other	6	33	...	14	10	14	5	31	9
Total Percentage	100	100	100	100	100	100	100	...	
Total Number	182	13	10	66	10	48	19	348	
Percentage of Total Referrals of Female Patients...	52	4	3	19	3	14	5	...	100

APPENDIX II B

NOTIFICATIONS OF MALE PATIENTS REFERRED FOR MENTAL ILLNESS TO SALFORD MENTAL HEALTH SERVICE IN 1962
BY SOURCE OF REFERRAL AND DISPOSAL (PERCENTAGES)

Disposal	Source of Referral								
	G.P.	Health/ Welfare/ Voluntary Organisation	Police/ N.S.P.C.C.	Hospital Psychiatrist	General Hospital	Relatives	Other	Total Number	Total %
Compulsory Admission	15	17	20	13	13	13	9	35	15
Voluntary Admission	34	33	10	13	38	36	9	71	29
Psychiatric O.P. or Domiciliary Visit...	18	...	10	9	...	11	...	32	13
Home Support (and G.P.)	22	33	20	50	50	21	27	63	26
Other	11	17	40	15	...	19	55	40	17
Total Percentage	100	100	100	100	100	100	100	...	
Total Number	131	6	10	31	7	47	9	241	
Percentage of Total Referrals of Male Patients	54	2	4	13	3	20	4	...	100

APPENDIX III

NOTIFICATIONS OF PATIENTS REFERRED FOR MENTAL ILLNESS IN 1962 BY AGE AND SEX

Age Groups	MALES		FEMALES		TOTAL	
	Number	Percent.	Number	Percent.	Number	Percent.
15–39 years	113	47	128	37	241	41
40–59 ,, ...	78	32	126	36	204	35
60–79 ,, ...	46	19	79	23	125	21
80+ ,, ...	4	2	15	4	19	3
TOTAL	241	100	348	100	589	100

APPENDIX IV

NOTIFICATIONS OF PATIENTS REFERRED FOR MENTAL ILLNESS IN 1962 BY DIAGNOSIS AND SEX

Diagnosis	MALES		FEMALES		TOTAL	
	Number	Percent.	Number	Percent.	Number	Percent.
Schizophrenia	93	38	95	27	188	32
Manic Depressive ...	26	11	93	27	119	20
Addiction, Neurosis, Psychopath	69	29	78	22	147	25
Senile...	14	6	30	9	44	8
Organic, Epilepsy ...	8	3	18	5	26	4
Non-Psychiatric ...	22	9	18	5	40	7
No diagnosis determined, others ...	9	4	16	5	25	4
TOTAL	241	100	348	100	589	100

APPENDIX V A

MENTAL ILLNESS

DISPOSALS FROM SALFORD MENTAL HEALTH SERVICE IN 1962
(Percent of Total Notifications)

Agency	Males	Females	Total
Compulsory Admission	14	12	13
Voluntary Admission	29	23	25
Out-Patient Domiciliary	13	21	17
Home and General Practitioner	27	35	32
Other	11	6	9
Not Taken On	5	3	4
Total Percentage	100	100	100
Total Number	241	348	589

APPENDIX V B

DISPOSAL OF ALL PATIENTS REFERRED TO MENTAL HEALTH SERVICE, 1959–1962*

Agency	1959	1960	1961	1962
Compulsory Admission	98	114	94	53
	52%	48%	45%	35%
Voluntary Admission	126	123	119	111
Out-Patient, Domiciliary	46	29	53	86
	48%	52%	55%	65%
Home and G.P.	110	146	144	157
Other	50	86	60	60
TOTAL	430	498	470	467

* Disposal at first notification in calendar year.

APPENDIX V C

DISPOSALS, 1959–1962 — INCEPTORS ONLY

Agency	1959		1960		1961		1962	
Compulsory Admission	46	53%	55	44%	37	43%	16	30%
Voluntary Admission	77		50		72		64	
Out-Patient, Domiciliary	28	47%	15	56%	35	57%	52	70%
Home and G.P.	58		67		83		90	
Other	24		52		28		38	
TOTAL	233		239		255		260	

APPENDIX V D

DISPOSALS, 1959–1962 — PATIENTS WITH HISTORY OF PREVIOUS ADMISSIONS

Agency	1959		1960		1961		1962	
Compulsory Admission	65	56%	84	61%	83	52%	47	38%
Voluntary Admission	66		75		66		74	
Out-Patient, Domiciliary	19	44%	15	39%	18	48%	85	62%
Home and G.P.	57		69		84		80	
Other	26		19		37		34	
TOTAL	233		262		288		320	

APPENDIX V E

DISPOSALS, 1959–1962 — PATIENTS WITH HISTORY OF TWO OR MORE PREVIOUS ADMISSIONS

Agency	1959		1960		1961		1962	
Compulsory Admission	48	62%	44	60%	53	57%	37	53%
Voluntary Admission	41		42		35		51	
Out-Patients, Domiciliary	11	38%	6	40%	9	43%	24	47%
Home and G.P.	33		37		35		44	
Other	10		15		23		9	
TOTAL	143		144		155		165	

APPENDIX VI

GENERAL PRACTITIONER REFERRALS TO SALFORD MENTAL HEALTH SERVICE IN 1962

Referral Rate*	Less than 1	1–	2–	3–	4–	5–	6–	7–	8–	9–	10–	11–	12–	13–	14–	15–	16–	17–	18–	Total
Number of G.P.'s :																				
1958	24	3	10	8	5	10	5	1	2	...	...	...	...	1	...	...	...	...	...	69
1959	16	23	5	9	6	6	6	1	1	1	...	...	...	...	...	...	...	...	1	75
1962	3	7	6	7	3	1	4	1	2	8	5	4	9	2	2	3	1	1	...	69

* Per doctor in each practice.

APPENDIX VII

DURATION OF STAY

DISCHARGES (EXCLUDING DEATHS) OF SALFORD PATIENTS FROM SPRINGFIELD HOSPITAL, 1959–1962

Length of Stay (in days)	Percentage of Patients in each Category			
	1959	1960	1961	1962
1—29	27·5	26·5	30·3	40·4
30—59	23·7	27·2	19·1	29·0
60—89	12·3	12·9	20·2	8·4
90—119	8·8	6·1	8·6	7·4
120—149	7·3	5·1	5·1	2·0
150—179	2·3	4·4	2·7	2·7
180—209	2·6	3·4	2·3	2·4
210—239	2·3	1·4	1·2	1·0
240+	12·9	12·9	10·5	7·1
	100	100	100	100
Number of Discharges	341	294	257	297

APPENDIX VIII

MENTAL ILLNESS

REFERRALS TO HOSPITALS FROM ALL KNOWN SALFORD SOURCES

Agency	IN-PATIENTS				OUT-PATIENTS				Grand Total
	Springfield	Salford General Hospital	Other	Total	Springfield	Salford General Hospital	Other	Total	
Salford Mental Health Service	199	16	10	225	...	45	...	45	270
General Practitioners and Others	117	7	9	133	...	366	13	379	512
TOTAL	316	23	19	358	...	411	13	424	782

APPENDIX IX

SALFORD ADMISSIONS AND DISCHARGES : SPRINGFIELD HOSPITAL, 1956–1962

Year	Admissions from Mental Health Service			All Discharges from Springfield Hospital		
	Male	Female	Total	Male	Female	Total
1956	135	169	304	173	198	371
1957	123	164	287	126	180	306
1958	126	148	274	135	146	281
1959	106	182	288	148	207	355
1960	100	148	248	134	194	328
1961	109	139	248	130	156	286
1962	89	110	199	156	176	332

In addition, in 1960 55 referrals, in 1961 65 referrals, and in 1962 117 referrals were admitted through sources other than Salford Mental Health Service.

APPENDIX X

THE CASE-LOAD IN MENTAL ILLNESS

	*1959	*1960	*1961	1962
A. Number of new patients referred† ...	233	239	255	260
Number of known patients referred ...	197	259	215	207
Total patients referred	430	498	470	467
Second and subsequent referrals during calendar year	73	89	85	122
Total referrals	503	587	555	589
B. Total number of visits‡	5,297	4,692	4,533	5,558
Number of officers (units time per annum)	6	5·6	§5·06	§6·63
Average number of visits per officer ...	883	840	896	838
Index of visits per officer	100	95	101	95
C. Average number of new patients referred per officer	39	43	50	39
Average number of known patients referred per officer	33	46	42	31
Average number of referrals per officer...	84	105	110	89
D. Average number of visits per patient referred	12·3	9·4	19·6	11·9
Average number of visits per referral ...	10·5	8·0	8·2	9·4
Index of visits per referral	100	76	78	90

* Amended from previous reports.
† Excludes patients notified from outside Salford (21 in 1962).
‡ Includes office interviews, visits to hospitals, etc.
§ Excludes trainees and Senior Officer who since 1961 has not undertaken case work.

APPENDIX XI

The Case-Load in Mental Subnormality

	1959	1960	1961	1962
Number of cases on register	669	681	686	665
Total number of visits	3,263	2,735	2,219	2,291
Number of officers	6	5·6	5·06	6·63
Average number of visits per officer	544	488	439	346
Average number of cases per officer	111	122	136	100
Average number of visits per case	4·9	4·0	3·2	3·5

APPENDIX XII A

New Notifications of Mentally Subnormal Persons, 1962

By Age and Sex

	Age								Totals 1962	1959	1960	1961
	0–4	5–9	10–14	15–19	20–29	30–39	40–49	50+				
Males	*5	1	3	2	*1	...	1	...	13	17	18	11
Females	*†12	1	...	2	1	...	...	...	16	24	20	15
1962 Total	17	2	3	4	2	...	1	...	29	...	...	...
1959 Total	13	6	8	12	2	...	...	...	...	41	...	...
1960 Total	7	2	2	19	1	3	3	1	...	...	38	...
1961 Total	11	4	...	3	2	1	4	1	...	...	...	26

* 4 cases migrated during 1962.

† 1 case died during 1962.

APPENDIX XII B

NEW NOTIFICATIONS OF MENTALLY SUBNORMAL PERSONS, 1962.

BY SEX, GRADE AND AGE

Grade	Males									Females									Totals Males and Females			
	Age								Total	Age								Total				
	0–4	5–9	10–14	15–19	20–29	30–39	40–49	50+		0–4	5–9	10–14	15–19	20–29	30–39	40–49	50+		1962	1959	1960	1961
Low	†1	...	...	...	...	...	...	...	1	3	...	...	...	...	...	...	...	3	4	8	3	5
Medium ...	*‡3	1	2	...	...	...	...	...	6	*6	1	...	1	...	...	...	...	8	14	13	10	10
High	*1	...	1	2	*1	...	1	...	6	3	...	...	1	1	...	...	...	5	11	18	24	11
TOTALS ...	5	1	3	2	1	...	1	...	13	12	1	...	2	1	...	...	...	16	29	§41	§38	26

* 4 cases migrated during 1962. † 1 case died during 1962. ‡ 1 informal assessment only. § 2 cases in 1959 and 1 case in 1960 unknown grade.

APPENDIX XII C

New Notifications of Mentally Subnormal Persons, 1962.

By Age and Source of Referral

Source of Referral	Age								Total
	0–4	5–9	10–14	15–19	20–29	30–39	40–49	50+	
Maternity and Child Welfare	11	...	...	...	...	...	...	...	11
Director of Education	1	2	1	2	...	...	...	...	6
General Hospital	4	...	...	...	...	...	...	...	4
Immigration	...	...	1	...	1	...	1	...	3
Others	1	...	1	2	1	...	...	...	5
Totals	17	2	3	4	2	...	1	...	29

APPENDIX XIII

ALTERATIONS IN STATUS OF MENTALLY SUBNORMAL PERSONS ON THE SALFORD REGISTER DURING 1962

BY AGE AND SEX

	MALES									FEMALES									TOTAL Males and Females
	AGE								Total	AGE								Total	
	0–4	5–9	10–14	15–19	20–29	30–39	40–49	50+		0–4	5–9	10–14	15–19	20–29	30–39	40–49	50+		
Discharge from Care	...	...	...	1	8	...	...	1	10	...	...	...	4	9	2	1	...	16	26
Migration	2	...	1	1	2	2	...	...	8	1	1	...	1	...	3	2	...	8	16
Deaths	1	...	1	2	...	...	...	2	6	1	1	...	1	...	...	...	...	3	9
Discharge from Institutions	...	...	...	1	3	1	1	1	7	...	...	...	1	...	2	...	2	5	12
Admitted to Institutions (long-term) ...	...	...	1	3	...	...	...	...	4	...	...	...	1	...	...	...	...	1	5
Temporarily admitted to Institutions ...	...	...	...	7	...	...	...	...	7	...	3	2	...	1	1	...	...	7	14
Waiting List for Institutions	...	...	...	1	...	1	...	...	2	...	1	2	1	...	...	...	...	4	6

APPENDIX XIV

ADMISSIONS TO AND DISCHARGES FROM INSTITUTIONS FOR THE SUBNORMAL OF SALFORD PATIENTS, 1953–1962

Year	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962
Admissions	12	12	7	3	3	9	6	10	6	5
Deaths in Institutions	5	2	2	2	...	...	4	7	1	3
Discharges	3	2	2	8	8	7	...	4	6	12

APPENDIX XV

ADULT TRAINING CENTRES AND PSYCHOTHERAPEUTIC DAY CENTRE — ADMISSIONS AND DISCHARGES

	ADULT TRAINING CENTRES			DAY CENTRE	TOTAL
	BROAD STREET	CRESCENT		CLEVELAND HOUSE	
	Male	Male	Female	Female	
TOTAL NUMBER ON REGISTER, 31st December, 1962	52	11	50	22	135
Subnormal	40	10	48	...	98
Mentally Ill	12	1	2	22	37
AVERAGE DAILY ATTENDANCE	39	46		13	98
TOTAL ADMISSIONS TO CENTRES	40	4	21	20	85
Subnormal	20	4	19	...	43
Mentally Ill	20	...	2	20	42
TOTAL DISCHARGES	38	5	11	24	78
Work	5	...	2	...	7
Hospital	2	...	1	...	3
Migrated	5	2	...	...	7
Died	1	...	...	2	3
Defaulted	25	2	6	13	46
Other Reasons	...	1	2	9	12

APPENDIS XVI

SUBNORMAL PATIENTS PLACED IN EMPLOYMENT FROM ADULT TRAINING CENTRES, 1962

	Age	I.Q.	Period Unemployed	Centre Attendance	Type of Employment	Result
MALES	30	39	Not worked previously because in hospital.	6 months.	Kitchen Porter : Hospital, 2 months. Labourer : Engineering, 2 months.	Lost second job through redundancy—returned to Centre.
	18	44	Not worked previously because in hospital.	3 months.	Cleansing Department Labourer, 2 weeks.	Dismissed for misbehaviour.
	17	47	5 months.	5 months.	Boxmaker.	Stable.
	27	58	2 weeks.	2 weeks.	Several jobs as General Labourer.	Changes jobs frequently but is regularly employed.
	20	84	Previously unemployed because in hospital.	6 months.	Driver's Mate for timber firm, 3 months.	Left job because of dispute with another employee—returned to Centre.
			Average	4 months.		
FEMALES	20	70	Not worked before.	5 years.	Hospital Laundry.	Stable.
	16	88	Not worked before.	1 year 5 months.	Packer, 2 weeks. Assembler, 2 weeks.	Lost job—returned to Centre
			Average	3 years 2 months.		

APPENDIX XVII

HOSTELS — RESIDENCES, ADMISSIONS AND DISCHARGES, 1962

		Males	Females	Total
Crescent ... 20 beds.	Number in Hostel on 1st January, 1962 ...	8	12	20*
Kersal ... 20 beds.	Number in Hostel on 31st December, 1962 ...	16	20	36

Admissions	Males	Females	Total
Number Admitted During Year :			
One admission only	27	20	47
More than one admission	6	7	13
Prime Reason for Admission :			
(i) No home	2	13	15
(ii) Lack of economic and physical resources for support of dependent patient	3	...	3
(iii) Half-way house from hospital	15	4	19
(iv) Need for protected environment for partially dependent patient (alternative to hospital)	11	3	14
(v) Short-term care (relief for family of a dependent patient)	4	3	7
(vi) Domestic tension	5	9	14
(vii) Leave from hospital	1	1	2
Diagnostic Categories :			
Psychosis	14	10	24
High-grade subnormality :			
(*a*) with behaviour disorder	6	5	11
(*b*) with psychosis	1	1	2
Medium-grade mental subnormality	8	11	19
Neurosis	3	7	10
Psychopathic personality	5	2	7
Not determined	...	1	1

Discharges	Males	Females	Total
Number of Persons Discharged During Year :			
One discharge only	18	19	37
More than one discharge	7	3	10
Prime Reason for Discharge :			
(i) Deterioration and admission to hospital	4	3	7
(ii) Delinquency and court action	3	...	3
(iii) Left by agreement	7	5	12
(iv) Placements (home, lodgings, foster care)	6	10	16
(v) Return home after short-term care	4	3	7
(vi) Left without consultation	8	3	11
(vii) Following leave from hospital	1	1	2
Obtained employment during year, after admission to hostel	8	4	12

* *Corrected from previous report.*

HOSTELS — RESIDENCES, ADMISSIONS AND DISCHARGES, 1962

Age Groups of Hostel Residents as at 1st January, 1962 :	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64
Males	9	4	6	3	2	7	1	5	...	...
Females	9	1	3	5	4	6	7	1	...	1
Total	18	5	9	8	6	13	8	6	...	1

Period of Stay in Hostel :	Less than 1 month		1–3 months		3–6 months		6–9 months		9–12 months		1 year or more	
	M	F	M	F	M	F	M	F	M	F	M	F
Patients discharged :												
Successful outcome (see iii, iv, vii above) ...	6	8	4	4	2	2	2	1	...	...	...	1
Unsuccessful outcome (see i, ii, vi above) ...	9	5	3	...	3	1	...	...	...	...	...	...
Short-term care (see v above)	3	3	1	...	...	...	...	...	...	...	...	...
Patients in Hostel at 31st December, 1962 ...	1	1	3	1	4	4	1	2	2	2	5	10

APPENDIX XVIII

MENTAL HEALTH DEPARTMENT — STAFF

	31/12/1961	Resigned 1962	Appointed 1962	31/12/1962
MEDICAL				
Senior Assistant Medical Officer (Part-time)	1	...	...	1
Assistant Medical Officers (Part-time)	2	...	...	2
CONSULTANTS				
Psychiatrist (two sessions per week)	1	...	...	1
Pædiatrician (one session per week)	1	...	...	1
EDUCATIONAL				
Psychologists (four sessions per week)	1	...	2	3
Remedial Teacher (Half-time)	1	1	1	1
Home Teacher (Part-time)	...	...	...	...
SOCIAL WORKERS				
Senior Mental Welfare Officer	1	1	...	...
Deputy Senior Mental Welfare Officer	...	...	...	...
Social Work Supervisor	1	...	...	1
Psychiatric Social Worker	...	...	1	1
Mental Welfare Officers	7 (inc. 1 part-time)	1	...	6 (inc. 1 part-time)
Trainee Mental Welfare Officers	...	...	2	2
ADMINISTRATION				
Administrative Assistant	1	1	1	1
Shorthand-Typists	1	1	2	2
Clerk	1	1	1	1
TRAINING CENTRES				
Supervisors	4	1	...	3
Assistant Supervisors	13	4	5	14 (inc. 1 temp)
Centre Assistants	2	...	...	2 (inc. 1 trainee)
RESIDENTIAL HOSTELS				
Wardens	2	1	1	2
Assistant Wardens	3	2	2	3

APPENDIX XIX

THE SPECIAL CARE UNIT. ITS RELEVANCE TO COMMUNITY CARE.

Dr. A. Wiseman reports :—

Special Care Units are gradually being opened up and down the country, and so far no common policy has emerged regarding the type of subject admitted and the type of training, staff and equipment required. In fact, there are varying opinions as to whether the work lies in the province of the local authority or the hospital.

In Salford, our Special Care Unit is concerned with two groups of children. One group is severely physically handicapped as well as severely sub-normal, along with a few children who are not sufficiently steady on their feet to be able to stand up to the activity of children without gross physical handicap. The other group consists of severely maladjusted or autistic children.

Several of these children would at one time either have been leading an isolated and bed-ridden existence at home, or have been admitted to an institution. In the Special Care Unit a number have become articulate and mobile, with the distinct possibility that they may outstrip the facilities of the Training Centre.

The group training of these children, however, requires to be backed by casework with the families, and good facilities for psychological, medical and educational review. An increasing volume of research concerns these subjects.

The Special Care Unit aims at a turnover based on improvement such that the individual moves on to a higher classification. Whilst this may be the aim, it is not easily achieved, but the measure of success is encouraging, and leads one to the view that a good deal more serious thought must be given to the possibilities inherent in Special Care Units by local health authorities, and by bodies such as the National Association for Mental Health whose courses for Training Centre staffs have been undergoing important changes of policy.

The conditions in the Centre are those of an ordinary nursery type unit, and no more than 5 children are cared for by any staff member. The groups are conducted in a kind of " family," and each staff member has regular care of 5 children. We do not believe that there is a child or adult in this field who cannot be stimulated ; there is no such thing as a human vegetable.

The waiting list for admission usually comprises about 6 children of various grades and ages. The families of such children carry a heavy burden, and the referral of the child frequently occurs at a time of particular family stress. It is therefore important that the waiting time should be kept as short as possible.

There is a need for greater facilities, for more research, for integration of services within the local authority, and not least, for more intense casework.

The facilities needed include equipment and new premises and training for staff. Present accommodation imposes severe limitations on the work, and the beginning of work on premises long planned is impatiently awaited.

Research can provide knowledge that is sorely lacking, and stimulate initiative and experiment. The programme of the unit received a great fillip when Dr. E. Lunzer, Consultant Psychologist, and Mrs. I. Hulme, Remedial Teacher, undertook a research project into the play patterns of very young severely sub-normal children. On the other hand, a research

programme can sometimes disrupt established patterns of activity, and it is necessary to help the staff to retain a flexibility of outlook and attitude which may enable them to adapt when their own familiar methods are superseded by new methods or by the requirements of research.

Integration of services and more intense case work should go hand in hand. For instance, the services of the Child Guidance Clinic should be more generally available to those attending the Special Care Unit. Educationalists are turning their thoughts towards this problem, but so far there are only small islands of child psychiatric work for the mentally retarded. Those with severe physical handicaps are more fortunate in this respect, but even they have not received the medical and psychological research which they warrant.

The turnover of cases during 1962, 4 admissions and 4 discharges with a complement of 20, gives some indication both of progress and of the slow rate of clearance that can be expected as time goes on.

APPENDIX XX

STEPPING STONES CLUB.

Dr. J. Leeson and Dr. R. Frankenberg report :—

The therapeutic social club, which is supported by the Mental Health Department but is run by an elected committee of members, continued to flourish. As before, the club met on Tuesday and Thursday evenings throughout the year in the premises of one of the Junior Training Centres, with occasional extra events such as coach trips, and evening concerts. In addition, members in hospital were visited and taken gifts and messages from the club.

The average attendances for 1962 showed a further rise to 49 on Tuesdays (compared with 32 in 1961) and 23 on Thursdays (compared with 17 in 1961). The rise continued during the course of the year, and in the autumn attendances of 50, 60 and on one occasion 80 were recorded. These large numbers were partly the result of the attractive programme, but were also associated with the entry of several new groups into the club. Problems arose as a result. Recruitment and integration of patients of some types hindered the recruitment of others.

A few people who had come under the care of the mental health service because they were designated "high-grade sub-normal" had attended the club for some time. They were mostly young men who in appearance and social behaviour were accepted as normal within the club. However, during 1962 other "sub-normal" people began to attend. At the beginning of the year, not more than 5 sub-normal persons attended club meetings, but by the end of the year there were up to 30 such people attending. These could be divided into three broad categories :—

(1) The first comprised middle-aged women from one of the hostels, who appeared physically normal and who were decorous in their behaviour.

(2) The second category were children and young people with physical stigmata of severe sub-normality, such as spastic diplegia or mongolism. Some of these were introduced by club members who worked alongside them at an adult training centre, while others were brought by their parents who were dissatisfied with the club for the mentally sub-normal which meets on Wednesday evenings. Amongst this group some behaved acceptably but others tended to be noisy, boisterous or lacking in social graces.

(3) The third category were teenagers from the hostels. They were physically normal for the most part, but formed a socially distinct faction in the club, demanding "pop" records, twist sessions and a " good time."

The club committee became concerned when severely sub-normal young people with physical stigmata began to attend. The teenager category was also not popular with some older members ; their youth may have made them less acceptable, for previously some normal neighbourhood children, who had formed the habit of coming in to play darts and table tennis, had been excluded. At any rate, the committee felt that sub-normal patients had their own club, and that the Stepping Stones Club was not intended for them.

The social workers were also doubtful about the admission of sub-normal patients into the club. They found themselves reluctant to introduce new members into the club when many sub-normal patients were present. When the presence of unsuitable members interferes with the facilities for the mentally ill patients for whom the club is intended, the mental health department must become concerned. The one responsibility which the department has reserved for itself in the club affairs is that of excluding undesirable or unsuitable members, and so any necessary decisions had to be made by the department rather than by the club committee.

The decisions are of great importance to the club, to individual patients and to their relatives. The decision as to whether an individual patient is suitable for the club rests with the social worker allocated to him. Overall policy on qualifications for membership is worked out by the mental health department. It would be a helpful guide to policy if more information were available on the attitudes of mentally disordered patients, both established members and newly recruited ones, to different categories of "sub-normal" patients and indeed on the attitudes of sub-normal persons themselves to categories of sub-normality other than their own.

Essentially, the problem seems to be one that faces all clubs. Within any large group, the formation of diverse groups and cliques can be expected in the course of its normal development, whether the distinctions are made by age, or social class, or more individual attributes of appearance and behaviour, or types of illness. Difficulties arise when the small groups have conflicting aims and interests, or conflicting images of self, and rejecting attitudes towards groups which represent an unacceptable image. The difficulties are greater when accommodation is not available which permits the groups to disperse, and so to find separate expression within the whole. New premises, with several rooms instead of only one large room as at present, might provide a simple solution to some of the difficulties.

The problem of selection for groups, and of individual identification with groups, is important not only in the social club, but also in hostels, adult training and industrial centres, and in psychiatric hospitals. Research into patients' attitudes in the club might find useful application in all these other situations.

APPENDIX XXI

CLEVELAND DAY CENTRE.

Dr. H. Freeman reports :—

The Day Centre at Cleveland House has continued to operate along the same lines as in previous years. Its activities are unfortunately very restricted due to limitations of accommodation and staff. It is, nevertheless, remarkable how much is accomplished within these limitations and how many patients are managed. The need remains acute for a substantial expansion of day facilities, particularly to accommodate men. A weekly visit is made to the Centre by the Consultant Psychiatrist and close co-operation is maintained with Springfield Hospital and the Salford Hospital Group. It would seem most desirable that a closer integration should be achieved between the present Day Centre for Women, the Adult Training Centres for the Sub-normal, the Stepping Stones Social Club, and the hostel accommodation. The desirability of bringing some or all of these facilities under a single roof might be a matter for consideration.

IMMUNISATION SECTION

During the year 2,467 children aged 0–15 years completed immunisation in Salford. The following figures show the results of the year's work :—

	0–5 *years*	5–15 *years*	0–15 *years*
Number immunised during the year ended 31st December, 1962	2,398	69	2,467
Total completed immunisation at 31st December, 1962	9,529	21,160	30,689
Population figures, 1962	13,900	23,000	36,900
Percentage immunised at 31st December, 1962...	69·2%	92·0%	83·1%

The children were immunised as follows :—

At Child Welfare Centres	1,771
By Public Health Nursing Staff in the homes of the children	481
By Nursing Staff at Schools	22
By General Practitioners	190
At Day Nurseries...	—
At Hope Hospital	3
TOTAL	2,467

Of the 2,467 children completing immunisation 2,455 received diphtheria pertussis and tetanus (triple antigen) injections, one received combined diphtheria and pertussis injections, four received diphtheria and tetanus, and seven were immunised against diphtheria only. One thousand and ninety-six booster injections of diphtheria and tetanus were given to school-children during 1962, and 1,141 children aged 0–5 years were given a booster dose of triple antigen twelve months after the completion of primary immunisation.

Whooping Cough Immunisation

Two thousand four hundred and fifty-six children were given protection against whooping cough during 1962. This number includes children who have received triple antigen and double antigen injections.

B.C.G. Vaccination

Appended are statistics relating to Mantoux tests and B.C.G. vaccination given to 13-year-old children :—

	Consents	Positive	Negative	D.N.A.	B.C.G. Vacc.
Boys	25	Nil	23	2	22
Girls	43	Nil	39	4	39
TOTALS	68	Nil	62	6	61

Poliomyelitis Vaccination

Oral poliomyelitis vaccination commenced during April, 1962, and three doses, each at a month's interval, were given to children who had had no previous polio injections. For children who had received two or three injections of Salk vaccine a booster dose of oral vaccine was offered. The following figures show the number of vaccinations (Salk and Oral) given during the year :—

Salk Vaccine	First	Second	Third	Fourth
Children 0–5 years (1958–62)	515	507	840	1
Children 5–15 years (1948–57)	41	56	262	20
Young people age group 1933–47	131	137	938	—
People 25–40 years	185	189	1,582	—

Oral Vaccination	First	Second	Third	Fourth
Children 0–5 years (1958–62)	1,684	1,413	2,176	82
Children 5–15 years (1948–57)	323	231	3,304	1,216
Young people age group 1933–47	209	166	1,339	1
People 25–40 years	272	200	1,668	—

The figures below show the total number of polio vaccinations given at 31st December, 1962 :—

	Completed Courses	Fourth Salk or Oral Vaccinations
0–5 years (1958–62)	5,951 42·8%	100
5–15 years (1948–57)	20,202 87·8%	8,693 37·7%
0–15 years (1948–62)	26,153 70·8%	8,793 23·8%
Young persons (1933–47)	17,080 63·0%	225
People 25–40 years	7,499 13·5%	—
Others	476	—

Smallpox Vaccination

Due to the cases of smallpox reported in Bradford early in 1962 the demand in Salford for smallpox vaccination was so great that it was decided to hold special vaccination sessions in the City. All the schools were visited for the purpose of vaccinating the children for whom parental consent had been obtained, and clinics were made available to the general public.

The figures relating to vaccination during 1962 are as follows :—

Age at date of vaccination in the year	Under 1 year	1 year	2–4 years	5–14 years	15 years and over	Total
Primary vaccinations	1,101	497	1,106	8,709	3,313	14,726
Re-vaccinations	3	6	276	6,761	8,553	15,599

INFECTIOUS DISEASES

The following table shows the numbers of infectious diseases notified during the year :—

Disease	All ages	Under 1 year	1–5 years	5–15 years	15–25 years	25–45 years	45–65 years	65 years and over
Scarlet Fever	25	...	8	15	2	...	...	...
Whooping Cough	4	1	1	2	...	...	...	...
Paralytic Polio	1	...	...	1	...	...	...	...
Measles	811	25	459	323	4	...	...	...
Dysentery	287	18	94	73	29	73	...	...
Meningococcal Infection	1	...	...	1	...	...	...	...
Pneumonia	48	1	1	2	7	9	17	11
Erysipelas	5	...	...	...	...	2	2	1
Food Poisoning	8	1	1	3	...	2	1	...
Ophthalmia Neonatorum	1	1	...	...	...	...	...	...
Puerperal Pyrexia	38	...	...	...	22	16	...	...
Rheumatism	9	...	...	9	...	...	...	...
Tuberculosis (Respiratory)	62	...	5	3	8	23	22	1
Tuberculosis (Others)	6	...	1	1	1	2	1	...
TOTALS	1,306	47	570	433	73	127	43	13

AMBULANCE SERVICE

The following table gives particulars of patients carried and mileage run during 1962, as compared with the previous year :—

Class of Patient	1962		1961	
	Patients	Miles	Patients	Miles
Spastics	4,988	6,768	5,672	8,033
Midwifery	2,769	12,458	2,460	11,476
House Conveyance	60,036	160,022	54,441	154,592
Inter-hospital	2,112	11,912	1,908	10,373
Maternity	1,554	9,965	1,648	10,571
Gas / Air	487	1,869	423	1,630
Mental Disorder	6,638	15,618	3,305	9,603
Rechargeable	250	3,129	254	2,427
Emergency	4,178	17,824	3,886	16,882
Miscellaneous	...	2,721	...	3,222
Infectious	206	1,336	224	1,529
Handicapped Persons	2,399	1,999	2,349	1,643
TOTALS	85,617	245,621	76,570	231,981

During the year, ambulances carried 74,839 patients and travelled 196,787 miles, and sitting-case cars carried 10,778 patients and travelled 48,834 miles.

At the end of the year there were in operation ten ambulances, three sitting-case ambulances and two sitting-case cars. The staff consisted of an Ambulance Officer, a Deputy Ambulance Officer, a Station Officer, three Shift Leaders, and thirty-six Driver / Attendants.

The increase in patients and mileage has been heavy in the mental health field and reflects additional patients conveyed to centres and clinics.

In the autumn, excavation work commenced on the site of the new ambulance station in Charles Street which is due to be completed by the end of October, 1963.

HEALTH EDUCATION

Anti-smoking Activities

A prominent feature of anti-smoking activities is a special clinic which is open to members every Monday evening from 7.30. Meetings are held in the Lecture Room of the Health Department and last for about an hour. More patients are sent by family doctors ; they are also attracted by notices in the local newspaper, poster displays and recommendation by friends.

On arrival members are welcomed—they sit in a large circle in order to promote free discussion. Generally, an introductory talk is given on aspects of smoking and health, stressing particularly the misery, as well as discussing the disadvantages, disabilities and diseases such as bronchitis and lung cancer caused by excessive smoking. But the important feature is to fortify the desire and decision of the patients to give up smoking, to deal with any individual difficulties they may have, and the development of a group spirit among the members. This is possibly the chief cause for whatever success the clinic has—to use the members' own words, there is the wish " not to let the team down " and also the desire to be able to voice the news of progress made in reduction or eradication, or of victory. Sometimes a spirit of emulation develops which is in part a reason for the success of the club. The progress of members is carefully watched and recorded. The number of visits are not restricted.

Physiotherapy is an important aspect of the programme. A senior physiotherapist attends all sessions, and an evening usually ends with a few stimulating exercises.

Mobile Unit

A mobile unit visited Salford in October, 1962, for five days. The unit, sponsored by the Central Council for Health Education, was designed to assist the local authorities in their campaign against smoking.

The unit was staffed by two graduates who were equipped with films, flannelgraphs and other publicity material.

The Health Department arranged talks to be given by the two graduates in schools, youth clubs, colleges and ante-natal clinics.

The campaign was primarily directed at the school-child and adolescent, and was favourably received by all heads of organisations.

Home Safety Committee

Home accidents treated at Salford Royal Hospital during 1962 :—

Cause	Male		Female		Total	
	Fatal	Non-fatal	Fatal	Non-fatal	Fatal	Non-fatal
Burns and Scalds	1	249	...	211	1	460
Falls	1	641	14	973	15	1,614
Lacerations	...	551	...	420	...	971
Poisoning	...	68	...	42	...	110
Overdose	...	34	5	80	5	114
Gas Poisoning	1	10	...	10	1	20
Swallowed Foreign Bodies...	...	99	...	96	...	195
Assaults	...	6	...	29	...	35
Miscellaneous	2	719	4	679	6	1,398
Totals	5	2,377	23	2,540	28	4,917

The committee continues to hold its monthly meetings. An exhibition on Home Safety is being arranged and will take place in Pendleton Co-operative Hall, Mill Street, Salford, in April, 1963. Twelve organisations have been invited to take part in the display with the common background of how to make home a safe place. A new handbook on home safety is envisaged in the near future. The committee are anxious to take part in any national campaign concerned with home safety and so help to reduce accidents in the home.

Health Survey

Special tests were provided for the people of Salford to ascertain the general standard of health. These tests started ten years ago with urine tests and have gradually been extended in succeeding years. The tests were entirely voluntary. Members of the public could have one or more of the tests as they pleased. No appointments were required but special sessions were put aside for persons not able to attend general sessions. Evening sessions were also held. The Health Survey, as it is now called, is getting increasingly popular. The results of abnormal findings were forwarded to the family doctors, with obvious exceptions such as height and weight.

The tests were carried out by nurses and auxiliary staff. The clerical work was done by members of the W.V.S.

The tests comprised :—

Blood pressure readings ;

Estimation of hæmoglobin (thumb prick) ;

Weight and height measurements (diet sheets were given out).

Vision tests : In the past a variety of tests have been used for faulty vision. These were found too complicated and now a simple vision test is given, and if anything abnormal is found, the family doctor is informed.

Hearing tests : By Audiometer.

Urine tests : For the detection of diabetes. Clinistix were used and each person was given one stick in a small envelope to take home. Instructions " What to Do " were provided on the front of the envelope, together with spaces for the results.

Questionnaire forms were also available for completion by the public. Typical questions asked were :—

Do you live in a Smoke Control Area, or in a house where no coal can be burnt ?

What do you think is the cause of cancer ? Would you welcome more information about this disease ?

Are you convinced that cigarette smoking plays a part in causing lung cancer ?

If you smoke, how much do you smoke a day ?

Would you try and prevent your children from starting to smoke ?

At what age do you think children should be given sex education ?

RESULTS OF TESTS :

2,657	urine tests	124	positive urine tests.
4,005	weighed	887	overweight.
3,795	vision tests	471	could not read 6/9 with each eye.
3,981	blood pressures ...	490	of these have systolic pressure above those regarded as normal for their age.
3,428	hæmoglobin	487	anæmic.

An anti-smoking campaign was also carried out and people were invited to join the Anti-smoking Social Club. Leaflets on smoking were distributed in the Hall.

Total attendances were 7,704.

Attendances for special tests alone were 4,015.

SALFORD HOUSE

During 1962 the average number of residents was 283 per night, a slight increase in comparison with the previous year, and the charges were maintained at £1 8s. 0d. per week, or 4s. 6d. per night.

Of the new admissions, several came from areas suffering from heavy unemployment, and were in the main unskilled labourers.

The high figure of residential pensioners continues ; in December a check revealed 142 old age pensioners and disabled men residing at the Hostel.

The National Assistance Board continued to work in close liaison with the management, and provided many needy cases with extra allowances and clothing grants. The W.V.S. also provided clothing to several retired and disabled men, and Booth's Charities supplied 20 pensioners with shirts and footwear.

The Health Visitor and Mental Welfare Officer are regular callers at Salford House, and co-operated with the management and local hospital officials in recommending a number of residents for admission to various convalescent centres.

The chiropody service is in great demand, and the old aged pensioners take full advantage of this beneficial treatment.

The Hostel was attended for one full day by the mobile X-Ray Unit, and 174 residents received examination, only three of whom required further attention.

The Hostel was visited by several parties of students from hospitals and welfare organisations, and by a party of almoners from local hospitals who wished to see the inside workings of a municipal hostel.

The traditional Christmas dinner was again a great success, and 140 old aged pensioners and disabled men enjoyed an excellent meal.

The new oil-fired central heating has been brought into commission, and is proving to be very successful and economical.

The Social Club is now well established and is of immense benefit to the residents. The Club helps residents, whether regulars or those who stay only a few nights, to develop friendly relations with their fellows, and removes most of the problems facing a stranger in strange surroundings.

That Salford House is well known and appreciated is demonstrated by the fact that every week letters are received from as far apart as Glasgow and London from men who wish to book a bed.

Generally speaking, residents agree that they receive excellent services for the cheap cost of accommodation. There are eight men now residing at Salford House who have lodged here for unbroken periods of over fifteen years each and others, who regularly travel up and down the country, visit the Hostel again and again.

Staff of the School Health Service

Principal School Medical Officer...	J. L. Burn, M.D., D.Hy., D.P.H.
Deputy Principal School Medical Officer.	D. H. Vaughan, M.B., Ch.B., D.P.H.
Medical Officer with Special Duties	D. W. Preston, M.B., Ch.B., D.P.H.
School Medical Officers...	Kathleen M. Boyes, M.B., Ch.B., D.P.H. Marian Maxwell-Reekie, M.B., Ch.B. Elizabeth Higham, M.B., Ch.B. Ariane G. M. Wiseman, M.B., Ch.B., D.P.H. Mary S. Gilbody, M.B., B.Ch., B.A.O., D.P.H. Dorothy Carlile, M.B., Ch.B., D.P.H. (*Commenced July*, 1962).
Part-time School Medical Officers	Marjorie F. Landau, M.B., B.S., M.R.C.S., L.R.C.P., D.C.H. Mary C. Murray, M.B., B.Ch., B.A.O. Eugenie Cheesmond, M.B., Ch.B. (Capetown). S. A. Silver, M.B., Ch.B. T. Fryers, M.B., Ch.B. (*Commenced October*, 1962).
*Consultant Ear, Nose and Throat Specialist.	P. Leeson, F.R.C.S.
*Consultant Orthopædic Specialist...	W. Sayle-Creer, M.Ch. Orth., F.R.C.S.
*Consultant Pædiatrician...	R. I. Mackay, M.B., Ch.B., M.R.C.P., D.C.H.
Part-time Oculist	J. Scully, M.B., Ch.B., D.P.H., D.O.M.S.
Orthoptist	Stella Thompson, D.B.O. (*Resigned July*, 1962).
Principal School Dental Officer ...	W. C. Parr, L.D.S.
Assistant School Dental Officers...	Agnes M. Paterson, L.D.S. A. E. Frankenstein, D.D.D., D.M.D.
Part-time School Dental Officers...	E. Blakeney, L.D.S. S. E. Turner, L.D.S.
Part-time Dental Anæsthetist ...	R. Bradbury, L.D.S. R. Bellingham, M.B., Ch.B., D.A.
Part-time Consultant Anæsthetist	Margaret O'Grady, M.B., Ch.B., D.A.
Part-time Consultant Orthodontist	W. B. Senior, D.D.O., R.F.P.S., L.D.S., R.C.S. (Eng.).
Oral Hygienist	Clarice Worsley.
Superintendent of Health Visitors and Nursing Staff.	Beatrice M. Langton, M.B.E., D.N. (London), S.R.N., S.C.M., H.V.Cert.
Senior Physiotherapist	Patricia K. Fogg, M.C.S.P.
Speech Therapist...	Greta M. Gordon, L.C.S.T.
Part-time Consultant Chiropodist...	Franklin Charlesworth, Ed.D., D.S.C. (Ohio), F.Ch.S.
Part-time Assistant Chiropodists ...	C. Newman, M.Ch.S. Margaret E. Charlesworth, M.Ch.S.
Audiometrician	K. S. Brown.
Chief Clerk	F. E. Birtwistle, M.R.I.P.H.H.

* By arrangement with the Manchester Regional Hospital Board.

SCHOOL HEALTH SERVICE ANNUAL REPORT

To the Chairman and Members of the School Health Sub-Committee.

Mr. Chairman, Ladies and Gentlemen,

I submit a report on the health of the school child for the year 1962.

Your aims of promoting the health of the school child are to lift it up to a high level and to maintain it there. Only in this way can every child be enabled to make the best use of the educational services provided.

By close collaboration with the field workers in the Health Department the School Health Service can see where any harmful physical and social conditions exist and try to take steps for those conditions to be remedied. The many aspects of the School Health Service described in this report show how the promotion and enhancement of the school child are effected.

The School Health Service is particularly anxious that parents should accept their invitations to attend the examinations by the school medical officer and the school health visitor. The parents can often give vital information as to a child's health which immeasurably assists the work of the staff. In return the medical officer and health visitor can more easily explain to the parents any problems concerning the child's health. Only good can come from such mutual discussions, and this is particularly true where the examinations take place at school and both parent and doctor gain the advantage of the reports of the child's teacher.

Thus the service is able to exercise supervision over the health of the school child. By such methods as these, any abnormalities or disease can be discovered in the early stages, and this often ensures speedy correction and cure.

The health survey is a valuable aid in the promotion of health. Surveys are undertaken by members of the School Health Visiting Service and are additional to routine medical inspection. Any defects are observed and reported to the school doctors so that the necessary attention can be given.

Clinics are available for the examination and treatment of various defects.

Minor Ailments Clinics are available for the treatment, by a school nurse, of such disorders as minor skin sepsis and disorders which require daily treatment.

Specialist supervision is provided for the examination and treatment of diseases of ear, nose and throat. This is not confined to children requiring operations for the removal of tonsils and adenoids, but also several other types of disease. There is treatment for hearing defects, which may be caused through catarrh ; children may be referred for the treatment of ear discharge, others may need a course of breathing exercises. Partially hearing

children may be sent to special classes to be taught lip reading and given instruction in the use of deaf aids.

Children may be referred to the Eye Clinic as a result of a clinic examination, or an examination at school, by the medical officer or health visitor. They may also be referred direct by head teachers or by the child's parents. Emergency cases such as injuries or inflamed eyes are treated immediately ; other cases are invited in the normal way. The child's eyesight is tested and it is an invaluable help if the patient's history can be obtained from an accompanying parent. Squint cases may be referred to the orthoptist for exercises and treatment, and the necessary instructions for continued supervision are given to the parent. Where necessary, glasses are prescribed.

Treatment of superficial eye disease is carried out at the clinic and, if necessary, surgical treatment is arranged.

Children may be referred to a chiropody clinic as a result of some defect observed at a health survey or a medical examination. Where this happens the defect is usually still of a minor character and so can be more easily corrected. The wearing of ill-fitting shoes, boots or socks often cause foot defects. The Chiropody Clinic seeks to advise parents on the problem of obtaining footwear which gives protection and support. Regular weekly clinics are held, and, in addition, large numbers of children are examined each year during special foot surveys.

Many forms of physiotherapy are available at centres throughout the city. These include postural drainage and breathing exercises for children suffering from bronchiectasis ; breathing exercises for children after tonsil and adenoid operations ; and for those suffering from asthma ; sunlight treatment for chest complaints, as well as remedial exercises.

Children with respiratory diseases and diseases of the chest are referred to the Consultant Pædiatric Clinic. The Consultant Pædiatrician, who is the specialist in children's ailments, prescribes the necessary treatment. Asthma (with its problems of whether allergy, infection or emotional disturbances form the cause), suspected bronchiectasis, primary tuberculosis, are some of the many diseases dealt with.

The School Dental Service carries out routine inspections in schools and, where necessary, children are referred to the nearest clinic for treatment. Relief of a child's toothache is, as far as possible, given priority. Normally, children are invited for treatment which includes not only extractions but also the various aspects of conserving and protecting the teeth.

The Orthodontic Clinic is for the treatment of malformed teeth. The consultant orthodontist is able to prescribe the necessary treatment and any dental appliances are provided.

The School Health Service provides special facilities for those children who, because of physical or mental handicaps, are unable to benefit from the normal educational services.

In these and other ways your service seeks to build up the health of the school child.

Summary

In the Salford School Health Service the staff try to follow the principles of preventive medicine :—

(1) To enhance the health of the schoolchildren.

(2) To prevent disease by trying to modify the harmful home and social environmental conditions in children, and by providing protection from an increasing number of diseases through immunisation.

(3) To give special care and after-care to those children who need it. This group form perhaps one in twenty-five of our children who sometimes need very greatly a strong comprehensive School Health Service.

Many thousands of our children are fit. These we can leave completely to the parent, whilst being available should any special need arise. Even these children, however, will need the continuance of the immunising procedures to keep up the level of protection against dangerous diseases.

But the group, which contains children suffering from various handicaps, physical, mental, educational, social, will require more rather than less help from the present and future School Health Service.

I take this opportunity of expressing my warm thanks to all who have helped the School Health Service in any way, and particularly the medical, nursing and administrative staff, for their devoted service. I am also grateful to you, Mr. Chairman, Ladies and Gentlemen, for your support. I wish to record my appreciation to Mr. F. A. J. Rivett, Director of Education, the teachers and staff of the Education Committee for their co-operation during the year under review.

J L. Burn

Principal School Medical Officer.

MEDICAL INSPECTIONS

During the year periodic medical inspections were carried out on 2,674 children. These inspections were carried out on school premises and all the children examined were born in 1956 or later.

The number of children found to have ear defects or enlarged tonsils and adenoids is still fairly high, but not as high as in 1961 : 2·8% of the children examined were found to be of unsatisfactory physical condition.

During the latter part of the year plans were made for the introduction, early in 1963, of selective medical inspections in secondary schools. Under this system questionnaires are to be distributed to all children in their first year of secondary education, for completion by the parents. School medical officers will then read the questionnaires and decide which of the children are to be medically examined. In addition, head teachers and school health visitors will be asked to submit the names of children whom they consider are in need of medical examination, especially those who are frequently absent from school.

School Clinics

In addition to the periodic medical inspections carried out on school premises, special inspections are carried out at the school clinics at Regent Road, Langworthy Centre, Police Street, Murray Street and Kersal Centre. Nearly 11,400 children actually attended the 1,046 school clinics which were held during the year.

Examination of Teachers

During the year, 112 candidates for employment as teachers were medically examined, and 109 of them were found to be free from physical defects or to possess defects unlikely to interfere with efficiency in teaching.

Also 42 candidates for entry to training colleges were medically examined, and 40 of them were free from physical defects or possessed defects unlikely to interfere with efficiency in teaching.

Educationally Subnormal Children

During the year examinations were carried out on 207 children who were considered to be educationally subnormal, or unsuitable for education at school.

The following recommendations were made :—

	Boys	*Girls*	*Total*
1. Education in a Day Special E.S.N. School	60	41	101
2. ,, ,, ,, Boarding Special School	1	...	1
3. Notified under Section 57	4	9	13
4. Education in an ordinary school	30	20	50
5. Education in a Day Open Air School ...	3	3	6
6. To be re-examined	27	9	36
Totals	125	82	207

The number of appointments made for the examination of educationally subnormal children was 267, of which 207 or 78% actually attended.

I.Q. ascertainments by School Medical Officers	124
,, ,, ,, Educational Psychologist	68
I.Q's. not ascertainable	15
Total	207

Number of examinations requested by :—

(*a*) School Medical Officers	161
(*b*) Educational Psychologist	28
(*c*) Head Teachers	14
(*d*) Director of Education	4
Total	207

School Medical Officers are still, by far, the largest source of referral of children who are in need of ascertainment under Section 34 or Section 57 of the Education Act, 1944.

INFECTIOUS DISEASES

Notifications of infectious diseases among Salford schoolchildren were as follows :—

	Boys	*Girls*	*Total*
Cerebrospinal Fever	1	...	1
Dysentery	40	32	72
Measles	173	148	321
Poliomyelitis	1	...	1
Acute Rheumatism	6	3	9
Scarlet Fever	5	10	15
Whooping Cough	2	...	2

VACCINATION AND IMMUNISATION

Smallpox Vaccination

On account of the cases of smallpox which occurred in some parts of the country, an intensive smallpox vaccination campaign was carried out from January–April, 1962. During this period 25,470 children were vaccinated either at school or in clinics.

Polio Vaccination

During the year, 5,450 doses of polio vaccine were given to schoolchildren.

B.C.G. Vaccination

Mantoux tests were carried out on 62 children aged 13, all of whom were Mantoux negative, and 61 of these children were vaccinated. The reason why very few children were vaccinated during the year is because most of the children in this age group had already been vaccinated in the B.T.A. survey carried out in 1960.

Diphtheria Immunisation.

During the year, 1,165 schoolchildren received diphtheria injections.

ACUTE RHEUMATISM

There are 73 children listed on the Acute Rheumatism Register at the present time. During the year ended 31st December, 1962, 9 cases of acute rheumatism occurring in children under 16 years of age were notified to the Medical Officer of Health. This gives a notification rate of 2·4 cases per 10,000 children. During 1961 there were 10 notifications of acute rheumatism, giving a notification rate of 2·7 cases per 10,000 children.

All the children on the Register are invited to the school clinic at regular intervals for medical examination, and every effort is made to see that the children attend. Those children who cannot attend the clinic will be seen by the school doctor during the Selective Medical Examinations (vide) which are due to begin in 1963.

Newly notified cases are invited to the clinic as soon after notification as is practicable but, occasionally, delay in seeing the child may occur, particularly if the disease is prolonged or if the child goes away for a period of convalescence.

Of the nine children who were notified during 1962, eight children attended the school clinic for medical examination, but one boy failed to attend and he will be examined at school. In each case the diagnosis of Acute Rheumatism was confirmed by a consultant pædiatrician and six of the children remain under supervision at a hospital out-patients' clinic. One boy, who is approaching school leaving age, has been advised to attend his family doctor for supervision and to attend an adult clinic, should the need arise, and two younger children have been discharged from the hospital clinic. In one case the attack of Acute Rheumatism was very mild, and in the other the disease has become quiescent.

A recurrence of the disease has occurred in only one case, a child suffering from chorea and, although there is no evidence of permanent cardiac damage, the child has been recommended for admission to an open air school. It has not been necessary to recommend Special Educational treatment for any other child notified to us during 1962.

Prophylactic penicillin has been prescribed for six children but is not considered necessary for the remaining three children. I am happy to report that seven children have escaped without suffering permanent injury to their hearts, but two boys have suffered minimal cardiac damage. Both these boys, and another child suffering from a limited exercise tolerance, have had their physical activities temporarily restricted, *i.e.*, they have been advised not to take part in competitive games and to stop any physical activity should they feel tired.

The Acute Rheumatism Register is difficult to keep up to date and a number of cases of the disease appear to occur without being notified to the Medical Officer of Health ; indeed, notification is sometimes requested by the Principal School Medical Officer as a result of chance remarks made by parents, teachers, or children themselves.

I would like to take this opportunity of reminding all doctors, both in hospital and general practice, that they are required under the provisions of the Acute Rheumatism (amendment) Regulations (1958) to notify, to the

Medical Officer of Health, all cases of Acute Rheumatism occurring in children under 16 years of age.

DEATHS AMONG SALFORD CHILDREN

During the year ten Salford schoolchildren died, five of the deaths being due to accidents and five to illness. Road accidents accounted for three deaths, there was one death due to a fall from a height and one child was drowned. Of the other five deaths, one was due to a brain tumour, one to paralytic poliomyelitis, one to acute leukæmia, one to peritonitis and one to acute asthma.

There were three deaths among handicapped children between the ages of 2 and 5, one death being due to spina bifida, another to bronchopneumonia in a child with a cystic lung, and the third to bronchopneumonia in a child with cerebral palsy.

THE HANDICAPPED REGISTER

The following table shows the number of children on the register of handicapped pupils requiring special educational treatment during the last two years :—

	1961	1962
Blind	5	7
Partially sighted	13	12
Deaf	17	18
Partially hearing	26	21
Educationally subnormal	504	411
Epileptics	1	2
Maladjusted	6	6
Physically handicapped	42	50
Pupils suffering from a speech defect	Nil	Nil
Delicate	280	249

THE SPECIAL REGISTER

A special register is kept of children who are suffering from certain disabilities, but who are able to attend ordinary schools, as the disabilities are not so severe that special educational treatment is needed.

The following table shows the number of children on the special register during the last two years :—

	1961	1962
Asthma	75	75
Partially sighted	20	18
Heart	49	47
Deaf	3	1
Partially hearing	56	53
Delicate	449	411
Physically handicapped	126	115
Epileptic	67	70
Multiple defects	25	28
Rheumatism	74	68
Diabetes	7	7
Speech defect	15	15

SCHOOL HEALTH VISITING

The health visitor is primarily responsible for school health " nursing," although she delegates certain duties to auxiliary staff. Her main functions are :—

1. Assessment of health of the children—in its full sense—physical, mental, emotional and social.
2. Counselling children and parents concerning assessment.
3. To act as link between home, school and school health department.
4. To further interchange of information between teachers and other school health visitors on all matters affecting the health and well-being of the child.
5. To discover and refer remediable defects and deviations from normal health to appropriate agencies for treatment.
6. To participate whenever possible in programmes for health education in school.
7. Special health care in relation to handicapped children—again the word " health " having physical, emotional and social connotation.
8. Investigation and follow-up of outbreaks of infectious disease.
9. To be concerned with the general hygiene of the children and of the school.
10. To collaborate with all appropriate statutory and voluntary organisations in the interests of the welfare of the child.

School clinic work of all kinds is delegated to clinic (State Registered) Nurses, who may, in addition, assist the health visitor with other duties. Nursing auxiliaries also help by carrying out duties which need for their performance the services of neither health visitor or nurses—head inspection, for example, weighing and measuring and certain tests, in addition to assisting at health surveys.

The development of school nursing from a function mainly concerned with personal cleanliness and care, head infestation and physical defects to the objectives set out above has not been easy and it is not yet fully developed.

The combined system of health visiting with school health work has shown many disadvantages and it is hoped in the near future to evolve a modified scheme which would embrace the better aspects of both combined and specialised school nursing.

With this end in view a group of schools providing both primary and secondary education for 3,000 to 4,000 children in one area was selected for a preliminary trial during the Christmas Term. A health visitor was made responsible for the full range of duties undertaken in the schools concerned and her general health visiting case load appropriately reduced. She was assisted by a State Registered Nurse for the treatment of children with minor ailments (now happily declining in number) and two nursing auxiliaries to carry out cleanliness inspections and certain tests under supervision and to assist the health visitor in carrying out health surveys and other work.

Under this scheme the health visitor aims to keep in close (weekly) touch with each school and to spread her work in schools over the year rather than concentrate examination of children into a few consecutive days each term and thereafter "leave the school in peace." The school health visitor needs to have a permanent and regular place in the life of the school, which will provide her with opportunities for continued health supervision and health education of the children, and for frequent and regular contact with teaching staff. Contact with teachers is important as they constantly observe children at lessons and at play, and are able to give the health visitor much valuable information especially with regard to problems of behaviour and signs of emotional strain which needs the health visitor's attention just as urgently as do physical defects. As a member of the general health visiting staff the health visitor is able easily to effect an interchange of information between the schools and the health visitors responsible for home follow-up of children living outside her own small area.

Apart from her own personal visits to school the health visitor arranges dates for cleanliness inspection, vision and other tests by mutual agreement with teaching staff. It is hoped that these arrangements will keep disruption of school activities to a minimum.

Health teaching individually or in small groups was carried out informally. Class teaching by the health visitor also took place in certain schools after normal school hours in connection with the Duke of Edinburgh Award Scheme.

This teaching includes First Aid, Home Nursing and Child Welfare ; subjects not only useful in themselves but which give the health visitor an opportunity to include occasional observations on other health matters—which often make a greater impact on the mind than a straight lesson. When teaching the function of the lung with relation to artificial respiration for example, she may touch upon the effect on the lung of cigarette smoking ; or in discussing the principles of asepsis in treatment of cuts and abrasions may mention the relationship between contamination of food and infected hands, and so on.

The subjects taught at these sessions might with advantage be incorporated into the general curriculum of all secondary modern and grammar schools. All girls should be taught the rudiments of home nursing and every child first aid, and both should know how to deal with health and sickness situations which arise from time to time in every household. Illness and accidents are no respecters of persons, and the child destined for an academic career is not exempt from this need. It is hoped to extend the range of subjects in health teaching in due course.

The general scheme was cordially accepted by teaching staff who have co-operated well and to whom our thanks are due. Good relationships between children and health visitor have been fostered by more frequent contact, and nursing auxiliaries have fitted smoothly into their appropriate role in the school health service. As the trial had been in operation for only one term it is too early to assess the success or otherwise. A full account will be given in next year's report.

School health work in other parts of the city was less intensive but following the same general lines, although it differed in organisation from the trial scheme.

During annual health surveys health visitors paid special attention to children in the twelve years to school leaving age group as periodic medical inspections were not carried out in respect of these children.

Individual children examined at health surveys totalled 19,200, of which 572 were recommended for further examination. Children referred to health visitors by teachers totalled 66.

Visual acuity tests were carried out in the 8–10–12–14 years and school leaver group. Illiterate children were tested by the "E" method ; 46·6% (1,455) of all children referred to the Ophthalmic Clinic during the year were referred by the health visiting section ; 847 of these were new cases.

Clinics

All school clinics were appropriately staffed. The incidence of minor ailments continued to decline and it is likely that a reduction in the number of clinic sessions will be made in the near future.

Open Air Schools

Daily visits by a clinic nurse were continued and liaison between the schools and health visiting section maintained as in former years.

School Journey—Holiday Camp

All requests for the examination of children prior to making school journeys or going to camp were met.

Verminous Infestation

Regular head inspections were carried out and infested children re-examined at appropriate intervals. The use of gammexane shampoo was continued, but there was again an unfortunate rise in the incidence of infestation from 4·77% in 1961 to 7·22%. Children disinfested by nursing auxiliaries was proportionately increased and numbered 48—more than double the figure of last year (23). The incidence of infestation was highest in the special schools, including the open air schools. A high proportion of the children attending these schools came from socially handicapped families and great difficulty was experienced in getting family members over school age, who may re-infest children, to co-operate in keeping themselves free from infestation. The standard of assessment remained high, *viz.*, the presence of one nit was considered an infestation and made as great a contribution to the high percentage as a head heavily infested with pedicule and nits.

Teaching

Every contact with an individual child provided an opportunity for health education which was not lost upon the health visitor.

Class teaching in school continued to expand, and as the popularity of the Duke of Edinburgh Award Scheme increased so did requests from schools for health visitors to give practical instruction. The teaching of the subjects concerned was classed as an out-of-school activity, although school premises were used for teaching.

Other groups were formed taking the same subjects outside the award scheme, and in yet other schools talks were given on personal hygiene and prevention of illness—all as part of the school curriculum. At the special request of one high school three talks were given on " Nursing as a Career " and on " Smoking and Lung Cancer."

Examination results in the award scheme were good and we would like to record our appreciation of the British Red Cross Society for conducting the examinations and providing certificates to successful candidates.

Classes were held in five secondary schools.

Examination results were as follows :—

JUNIOR FIRST AID

Part I :	Entered	51	
	Passed	51	(proficiency, 1)
Part II :	Entered	11	
	Passed	11	

CHILD WELFARE

Part I :	Entered	43	
	Passed	43	(proficiency, 5)

We are grateful to the Head Teachers in all schools concerned for their help and co-operation in this work.

Educationally Subnormal Children

A special scheme was also started in the Christmas Term to give particular attention to educationally subnormal children attending Broomedge and Parkfield Schools. The aim was to give special supervision to the children in schools in collaboration with head teachers, and to visit the homes in order to influence where necessary parental attitudes towards the children's disturbed behaviour and slow progress.

The health visitor's general health visiting case load was reduced but not substantially, and it was impossible therefore for her to visit in this one term all the homes of the schoolchildren concerned.

Head teachers of both schools welcomed the idea and were able at the outset to refer certain children considered to need priority care.

Problems encountered included the following :—

1. Poor maternal health combined with low I.Q. and fluctuating income ; poor physical and emotional care of children. Frequent visiting was required here before a relationship could be formed and the mother persuaded to consult her doctor and to attend the Day Training Centre in the first instance.
2. Incomplete family due to parental desertion—emotional difficulties of a parent reacting on the child—no proper care for child during school holidays whilst mother sole supporter of the family, leading to minor delinquency—partial rejection of child when mother found another partner.
3. Low income, low parental I.Q., large family—poor standard of cleanliness, inadequate clothing, poor parentcraft. Much material help was a necessary preliminary to work with this family.

4. Overprotected child.
5. Very disturbed child with severe behaviour problems—one of large family, mother at the end of her tether.

Endeavours were made by the health visitor to establish good personal relationship with the parents in so far as was possible in the short time available. Discussion with and referral to a Child Psychologist was made in all appropriate cases. A full report will be available next year.

NURSERY CLASSES AND NURSERY SCHOOLS

Nursery Classes

It is now over ten years since a request came from a small group of headteachers of infant schools asking for the " under fives " to have a " Special Medical." This began with the four schools who asked for it and then after four years it was extended to a further three making seven in all. Now all schools with an "Admission Class " are visited. Great care is taken to avoid visiting the school in the same term as their Periodic Medical Inspection, nevertheless each school is visited once each year. Two schools were visited twice, on both occasions the children examined had NOT been examined before by the School Medical Officer for this work.

When the infant classes first had these " Extra Medical Inspections " it was because the mothers of the children were all busy with war work. When the war ended the visits ceased after a while, but a few of the headteachers asked for them to be re-started in their schools. The children in the *Nursery Schools* were then seen once a month and the idea was that the children of a similar age group in the *Nursery Classes* should also be seen once a month. This was done for a few years, but when the number of classes increased, the visits became reduced to once a term and now to once a year. Ideally, it would be a good thing to examine the new children when they enter, but this is not always possible.

During the year, 186 different children (110 boys, 76 girls) were medically examined and by far the greater number are healthy, happy and well adjusted—only two were found to be unsatisfactory. No child was seen twice at an " UNDER FIVE " Medical Inspection.

The total number of defects—212—is about the same as in past years. Teeth (63) and enlarged tonsils and adenoids (35) are the most frequent. When it is reported that only 65 children had bad teeth it means "obviously" bad teeth, the remaining children had extractions or fillings, only a few had an apparently good set of first teeth.

Eneuresis is not common during the daytime but a few mothers said their children wet the beds at night.

The Nursery Classes visited were in the following schools :—

Nashville Street (1)
Ordsall (1)
North Grecian Street (1)
St. Joseph's (1)
Blackfriars Road (2)
Trafford Road (1)
West Liverpool Street (1)
Lower Kersal (1)
Marlborough Road (1)
St. Sebastian's (2)
St. John's R.C. (1)

The number in brackets indicates the frequency of visits.

Nursery Schools

During the year a total of 15 visits were made and 195 different children examined. The health of the children continues to be good, only three being found unsatisfactory : the majority abounding in vigour. In September it was decided that three of the Nursery Schools should have three groups of children, *i.e.*, some " all day," some " mornings only," and some " afternoons only." This alteration seems to be working well and it enables an extra 15 to 20 children to be cared for at the three Nursery Schools.

Amongst the defects found " carious teeth " still comes out top, although there has been an improvement ; more children had fillings in their first teeth which is an indication of greater care and interest by the parents. Enlarged tonsils and knock knees were found in 38 and 20 children respectively.

For some children half a day at the Nursery School is quite long enough and they are ready to go home with their mothers when the time comes.

Once again the co-operation of the headteachers in discussing the problems of some of the children is appreciated and in many cases early troubles have been eased.

SCHOOL DENTAL SERVICE

W. C. Parr, L.D.S., *Principal School Dental Officer.*

During the year we were unfortunate to lose the services of Miss Worsley who left the service to commence teacher training. Some considerable dislocation was also experienced by the resignation and replacement of two surgery assistants necessitating curtailment of clinics for a short time.

The new clinic at Kersal Centre became available for use early in the year, being staffed jointly with the Police Street Clinic, and worked for one day per week to serve children attending the schools from which the Kersal Centre was reasonably accessible. This did not affect the system by which the individual clinics were made responsible for the inspection and treatment of the schoolchildren in the area in which the clinic was situated.

Thirteen thousand one hundred and seventy-seven schoolchildren were examined at routine school dental inspections during the year. These inspections cover all age groups attending the various schools inspected. Schools are inspected in rotation by the staff of the individual clinics in their respective area and, as a result, some variation in the frequency of examination occurs from one district to another. It is not the practice at these examinations to attempt any assessment of relative individual dental condition, but inspections are carried out to ascertain which children are in need of dental treatment, and the type of treatment required, in order to facilitate their subsequent invitation for this purpose. Where it is obvious, on examination, that children are already receiving dental treatment no referral is made, otherwise treatment is offered to all children found to be in need of it. On examination such children are given a printed form to take home to their parents informing them that the child is considered to be in need of treatment and offering the services of the School Dental Service for this purpose. Whilst it is realised that this method, relying as it does on the co-operation of the children and teachers, is by no means a completely satisfactory way of communicating with the parents, in view of the great numbers involved any more certain way would prove to be far too uneconomic.

Some 3,200 children were examined as " Specials " in the clinics. These children are seen either at the urgent request of doctors, health visitors, teachers, etc., or on their presenting themselves at the clinic in some form of dental discomfort. Of children seen in this way almost all of them require treatment and are offered it. This factor should, therefore, be born in mind when the statistical tables showing the numbers offered and receiving treatment are considered. Regrettably many of these children delay the request for treatment until such time that a general anæsthetic is necessary, involving some delay, with consequent further suffering. Little change is shown in the number of fillings inserted during the year, nor in the figure of " other operations." This latter item consists largely of a variety of conservative procedures, whilst the item for temporary teeth refers almost exclusively to the number of teeth which have been treated by silver nitrate as a conservative measure. An increasing number of acrylic jacket crowns have been inserted for older pupils. These crowns were fitted to complete the conservation of incisor teeth fractured accidentally in a number of ways and for which it had been possible to preserve a vital pulp until the root development was completed. In one instance a crown of the post or dowel type was fitted but, in general, root treatments are avoided, and only carried out in exceptional circumstances.

Seventy-nine pupils were provided with dentures. The majority of these were one- or two-tooth dentures provided to replace broken incisors for which treatment to preserve the pulp and subsequent crowning, as above, was not possible either because the treatment could not be commenced sufficiently quickly after fracture to prevent the loss of vitality of the tooth, or where a crown was not deemed to be suitable for the child. Only a very few of such dentures were inserted as a result of dental caries.

Teeth extracted, both temporary and permanent, are at about the same level as in previous years, as are the number of General Anæsthetics administered. During the year the practice of administering " Fluothane " as an adjuvent to nitrous oxide and oxygen anæsthetics was introduced for selected cases.

The policy of commencing orthodontic treatment for a new patient to replace one for whom treatment has either been completed or discontinued means that the number of children in receipt of this treatment remains constant at all times. During the past year the number of sessions given to this work was, unfortunately, less than in previous years, due mainly to practical difficulties which have now been eliminated. There has been, in consequence, an increase in the number of children awaiting this treatment and a further delay in commencing treatment for children for whom it was recommended. When such recommendations are the result of routine school dental inspections the delay is of little consequence since the notification can be made sufficiently well in advance of the need for active treatment. Requests for orthodontic treatment from other sources, however, create difficulty as the request is usually made at an age when treatment cannot be further delayed if it is to be reasonably successful. In many such cases, particularly where there is overcrowding, it has been found expedient to bring about such improvement as could be obtained by extraction alone without the patient having to wear any appliance. Wherever possible simple irregularities are treated at an early age if such procedures are judged likely to avoid prolonged treatment later. The number of cases which are discontinued for lack of co-operation, loss of interest, etc., whilst still a problem does, however, seem to be diminishing and every effort is made in the selection of cases for orthodontic treatment only, to commence treatment where there seems to be good reason to suppose it will be completed.

Some 815 children (who made 1,554 attendances) were seen by the oral hygienist. These children were referred to her for treatment either by dental officers or at the request of the school medical officers. The teeth are scaled and cleaned and the children are instructed in the proper way to maintain a healthy mouth. For some of them it is found necessary to carry out gum treatments for a limited period. These children are re-invited by the hygienist after a lapse of some six months for a further check-up and any necessary treatment.

It was the practice of the hygienist to accompany the school dental officers on routine dental inspections in schools in order to discuss their hygiene with the children, either in small groups or whole classes, and to stimulate their interests by means of talks, posters, models and to distribute pamphlets on the subject. The co-operation of the teaching staff in these activities has been readily available. It is regretted that these activities ceased on the resignation of Miss Worsley for whom it has not yet been possible to find a replacement.

SPEECH THERAPY

The past year has seen no additions to the staff but it is hoped there will soon be some improvement. Meanwhile in Salford those children who require urgent treatment are being dealt with as expeditiously as possible, ahead of the rest. A number of children, particularly the very young, have been home-visited, their speech assessed and the parents advised as to the best way of helping their children. In many cases the home is again visited at regular intervals to ascertain progress.

Throughout the year speech-therapy students have attended once or twice weekly at one or other of the clinical centres in Salford—a useful preliminary introduction.

During March, talks on Speech Therapy—with special reference to the young child—were given to the Nursery and Infant Teachers' Association at the Education Office, and to a group of student Nursery Teachers at Chaseley Field Education Centre.

The Child and his Home

The Psychological Aspect of Speech Disturbance

Quite a lot of speech trouble in children is found to have an emotional basis, generally traceable to some factor or factors in the home. While it is evident that these children have a predisposition to speech difficulty—as seen by the fact that other children, faced with similar circumstances, develop normal speech—this could in many cases be prevented or controlled by an intelligent and sensible attitude and by wise and sympathetic handling on the part of the parents. In addition, these children would appear to be more sensitive and vulnerable than the average child and, consequently, more prone to upset by adverse conditions. Hence, a good many of the speech troubles which arise are due, wholly or in part, to emotional disturbance, the source of which invariably lies in the home, and is most frequently associated with the mother.

The child needs to have a sense of security in order to progress satisfactorily, and it is vitally important that parents should accept their child at each developmental stage and, in particular, avoid unfavourable comparison

with a brother or sister who perhaps appears to be more intelligent or gifted. In accepting their child parents recognise his individuality and suit the pace to match his own, loving him for what he is, as he is, at every stage. Thus, the child is encouraged to learn and develop. This does not mean lack of discipline on the parents' part. The child who is " given-in " to, and gets his own way at every turn, is anything but secure. He needs to feel that his parents are in control—and it is essential that there should be united control. Quite often it happens that one parent attempts to be firm, while the other (usually the mother) undermines this by disputing her husband's authority, and the child, although frequently quick to press home his advantage—with pleadings, tears and temper—yet feels insecure and unhappy. This, too, often finds expression in some form of speech disturbance. Where a state of parental disharmony exists there will be tension in the family atmosphere, and the parents may vie with each other for their child's affection, causing conflict in the latter, who is torn by divided loyalties.

It happens too, in many cases, that a child has been delicate in infancy, had a series of illnesses, or a long stay in hospital, and the parents thereafter misguidedly continue to coddle and spoil him. This, apart from being disastrous for the child, often has repercussions on the rest of the family who may become jealous at the attention shown.

The youngest child in a family is frequently over-protected and prevented from making the necessary effort, particularly where there is a big age gap in the family between the youngest child and the next. Elder brothers and sisters rush to answer for him, and assist instead of letting him do things for himself (elder sisters particularly). His mother, all too easily, interprets his every want, so that a mere grunt or gesture suffices. The result is that the child's speech and general development is often slowed down or arrested, and he becomes lazy, or lacking in self-confidence.

Then there is the child who, hitherto the youngest in the family, now finds his position usurped, and himself out in the cold—or so he feels. He may quite likely indulge in rages, and becomes generally " difficult," or else reverts to infantile speech and habits, in an effort to regain his mother's attention, unless great care is taken to preserve the balance. One such mother, whose youngest son was stamping about with rage, while she nursed his little sister, was heard to exclaim to a visitor : " I've told him I'm going to have him put away." Stupid threats of this sort can undermine a child's faith in his parent, make him feel still further estranged, and, perhaps, cause downright fear, again fostering insecurity.

In the case of an only child, the parents are sometimes over-ambitious, seeking to press the pace, and suffer consequent disappointment if their efforts fail to bring about the desired result. The effect on the child may be such that he digs his toes in and calls a halt to further progress. Stammer or speech defect may appear as a defence mechanism.

The child who comes in the middle of a large family often tends to be overlooked. He or she may strive for attention by exhibiting some form of speech abnormality or by untoward behaviour or, again, lapse into a state of negative apathy.

There is the unwanted child who suffers emotional deprivation (and possibly, also physical neglect) through lack of parental love and affection. If the mother is a good and conscientious person she may feel a sense of guilt

over her unwanted child, and try to assuage this, by taking inordinate care. Some mothers are over-possessive, and seek to keep their children young and dependent on them as long as possible. All this can play havoc with a child's natural development. He may become nervous and timid, lacking in initiative and concentration, and backward in speech, or else stammering.

The mother who is too house-proud is quite often guilty (usually unwittingly) of putting her house before her child. Such children are not allowed to play freely, and are required to keep clean and tidy at all times. A case in point is that of a boy under seven years of age who showed an appalling tension stammer. Fortunately, for him, his mother was seen by a psychologist, who advised her to put a heap of sand and some water by the wall of her house, dress the child in his old clothes, and let him mess about with this to his heart's content. The effect on the stammer was magical, in a little over a week it had completely disappeared. No doubt, too, the mother's sincere wish to help her child effected a complete change of attitude with regard to her house.

Another factor which may give rise to speech and/or behaviour problems is inconsistency of handling. Some parents shout at and punish their child one minute and condone the next ; or they may try alternate bribery and threats, in an effort to make the child obey.

A mother's disappointment over her child's sex can also give rise to trouble. The mother who fails to reconcile herself and indulges in futile longing is, in a measure, rejecting her child, and this will inevitably communicate itself through her manner, if not in actual words, to the child concerned, the effect on whom may be one of anxiety or other emotional disturbance, accompanied by a sense of insecurity.

Many young children (about 3–5 years of age) go through a quite normal stage of jumbled and hurried speech, owing to the mind working much faster than the speech mechanism, but they should gradually adjust themselves in time, providing nothing is done to upset them, and parents should guard against any show of anxiety or impatience about the speech, in fact, leave well alone ; otherwise the child may become disturbed, and so develop a stammer. Parents should speak slowly and clearly to their child and give plenty of time for answer, also listen carefully to what he has to say. Where a stammer is already present, the parents can best help their child by refraining from any attempt at correcting this, and by avoiding remarking on the stammer in front of him.

OPHTHALMIC CLINIC

(Dr. J. Scully)

During 1962 orthoptic supervision has been given to 143 new cases of squint ; 55 girls and 88 boys and occlusion treatment has been given on 3 592 occasions, comprising 1,553 girl attendances and 2,039 boy attendances. Orthoptic treatment on the synoptophore has been given on 250 occasions, comprising 131 girl attendances and 129 boy attendances. The full-time Orthoptist left the Department on 6th July, 1962, and orthoptic treatment since that date has not been given to any child. During the summer and autumn of last year and the early months of this year the synoptophore has been used to measure angles of squint before and after operation. Since the departure of the Orthoptist the staff of the ophthalmic clinic have continued

the occlusion treatment of children of pre-school and school age, and no child requiring such treatment has been allowed to go by default.

In addition to the normal work of the ophthalmic clinic it has been possible, during the last twelve months, to give continued attention to the amblyopia of squint, with special reference to the factor of eccentric fixation which occurs in that condition. Each case of strabismus, as it attended the clinic, either as a new case or as a repeat visit, was first refracted and then examined with the visuscope when the pupil was dilated. A detailed history of each new case was made, having regard to the following details—date of birth, age at onset of squint, interval of time between onset and first attending for treatment, family history, possible cause of squint and degree of refraction. There was found to be a statistical difference in the incidence of non-central fixation between treated and untreated cases. A series of more than 150 new cases showed a percentage of 25·3 having accentric fixation and a further series of conventionally treated cases of a percentage of 15·2 with eccentric fixation. The children having a later age of onset of the squint were less likely to have non-central fixation compared with younger children, but the operative factors tending to increase the incidence of non-central fixation were the interval of time between onset and first treatment and the degree of anisometropia. These factors were independent of each other. Of these factors, age at onset ; interval of time between onset and treatment ; and the degree of anisometropia ; the first two are subject to influence as a result of medical inspection. The inference which has been drawn suggests that squint in children should be ascertained and treated as soon as possible in order (1) to treat the children in the younger age groups, who show a greater likelihood of developing eccentric fixation, and (2) to curtail the interval of time between onset and treatment in order to diminish the likelihood of eccentric fixation developing in the untreated case. With these objects in view, the family doctors and the school medical staff of the local authorities have been circularised suggesting that cases of squint should be sent for treatment immediately they are discovered.

During the last twelve months inverse occlusion of the squinting eye has been practiced in the large majority of new cases of squint with eccentric fixation and in this period of time central fixation has been achieved not more than 90%. At a certain stage in the treatment, varying between 6 and 9 weeks, the inverse occlusion has been transferred to the opposite eye so that conventional occlusion is continued from that date. It is found that inverse occlusion followed by conventional occlusion is the most satisfactory method of achieving central fixation.

CONSULTANT ORTHOPÆDIC CLINIC

Continued experience of the work of the Orthopædic Clinic confirms the usefulness of this part of the Salford School Health Service. Physiotherapy is ordered and the results assessed. For those needing operative treatment the close liaison with Hope Hospital continues. Surgical appliances are supplied as usual through the appropriate channels.

There have been no epidemics of polio for some years and very few new cases requiring orthopædic supervision have been seen. Spastic children are now being diagnosed and treated at an early age, so that the badly crippled and affected child is less frequently seen. The occasional case of muscular dystrophy requires such treatment as is possible. The majority of the new

children are mild cases of knock knees and flat feet, for which treatment is given. It is gratifying to note how the close co-operation between all branches of the health and school health services is resulting in the production (if one may use the word) of a healthy and beautiful new generation of children.

PSYCHIATRIC CLINIC

During the year 26 schoolchildren and five pre-schoolchildren were referred to Dr. Gage, Consultant Child Psychiatrist, at Regent Road Clinic. Most of these children were referred by school medical officers.

Dr. Gage's clinic is a new development for the treatment of emotionally disturbed children and it is hoped that more use will be made of this clinic in the future.

PHYSIOTHERAPY

As usual we have worked through a busy year but a satisfying and a happy one.

The physiotherapists have all worked hard but co-operated well together and without friction. During the whole of the year we were one physiotherapist short, which out of a staff of three was a third, and this naturally made working conditions harder. A small staff suffers hardest during unavoidable illness of any member and frequently means that people return to duty before they are quite fit, as they have a guilt complex thinking of the extra work for the remaining staff. Human beings are not like papers on a desk which can be placed in a drawer until tomorrow.

The Claremont Open Air School at present provides the largest single unit of work for the physiotherapy staff. There are 210 children in the school and two-thirds of them have some form of physiotherapy whilst in the school.

As school hours are short and teaching staff are naturally anxious to have as little interference as possible during lesson periods, it is only by the closest co-operation between teachers and physiotherapists that arrangements, suitable though never perfect, have been worked out so that the child has the necessary treatment and at the same time misses as little lesson time as possible. That this has been achieved is shown by the fact that four children obtained grammar school or technical school places during the year. Two of the children have been having daily treatment for asthma during the whole of their school period.

During the long severe winter not one of the children with bronchiectasis had pneumonia. They all had twice daily chest drainage at school and aerosol inhalations and were encouraged to drain at home before bedtime. The teachers co-operated by watching that the children did not play out on foggy damp days and all the children kept very well. One child is making good progress after a lobectomy and another has recovered so well that an operation will not now be required.

The physically handicapped senior children have enjoyed their weekly visit to Blackfriars Road Baths, which the attendants keep extra warm for them, a physiotherapist and a teacher accompany the children and, even the

most severely handicapped children who are unable to walk, have learnt to swim on their own, which has given them a wonderful feeling of achievement and independence.

During the summer months the very young physically handicapped children, by the kind invitation of the headmaster of Light Oaks School, made a weekly visit with a physiotherapist and a nursery warden to the small pool in the school swimming baths, and had great fun doing exercises and playing games in the warmed pool. The children from the cerebral palsy unit at Cleveland Special Class also joined in the fun, and became much more relaxed and confident.

A physiotherapist accompanied the school on two one-day expeditions to the Lake District, this enabled some of the more severely handicapped children to be included in the party, and it was doubtless the first time that children with severe bronchiectasis had done chest drainage over a coach seat in view of Wordsworth's daffodils.

In the school clinics the physiotherapists tried hard to keep an appointments system to minimise the time a child was away from school and so not to impose too great a burden on the mother. If a child was on both artificial sunlight and exercises it was arranged that both treatments should follow simultaneously and the mothers were encouraged to help the children practice their exercises at home to cut down their length of attendance at the clinics.

The new Kersal Centre started slowly, as was to be expected, but the numbers are increasing steadily. The clinic is a very pleasant place in which to work but, unfortunately, it has been planned without one room large enough for a remedial exercise class.

The orthopædic consultant and medical officer clinics have worked well. A progressive step has been taken—instead of the same medical officer seeing all the children after completing a course of physiotherapy, the children are invited back to the area doctor who prescribed the treatment in the first case. This has prevented much overlapping with clinic invitations and has led to closer co-operation between the doctors and physiotherapists.

AUDIOMETRY

Of the 6,187 children in Salford schools who are in the 5–7 year age group, 6,034 underwent a sweep test of hearing in school, 631 failed and were referred to the clinic so that an audiogram could be obtained. A large percentage of children in their first year at school failed the hearing test, this was probably due to their having little resistance to germs they are meeting for the first time, and they are, therefore, prone to enlarged tonsils, glands and adenoids. A greater percentage of children from poorer homes also failed the test. A further influence in the hearing test failures was the weather as, during spells of inclement weather, an alarming number of children had impaired hearing. Colds and catarrh were chiefly to blame. As a matter of routine, all children attending Fernhill School had a hearing test, as also did children involved in road accidents, educationally retarded children and children needing speech therapy. In all, 3,300 individual audiograms were obtained during the year.

The 1958 Annual Report stated that without a soundproofed room accurate tests could not be undertaken. Many of our children have to go into Manchester for bone conduction tests and speech discrimination tests. Both these tests could be performed at a School Health Clinic if a soundproofed room were available. The present facilities available can only be described as deplorable and are very much inferior to the facilities provided by other authorities. One can only hope that in 1963 sufficient money will be available to provide a soundproofed room, otherwise mothers will continue to travel into Manchester with their children for tests at considerable inconvenience and expense.

Further, recheck audiograms are still necessary at the expense of the School Health Service.

SCHOOL CHILDREN'S CONVALESCENCE

Number referred	60
,, refused	5
Not yet placed	3

34 children were away for four weeks or less.
2 ,, ,, ,, ,, five ,,
9 ,, ,, ,, ,, six ,,
7 ,, ,, ,, ,, eight ,, or more.
52

Sources of referral :

School Medical Officers	51
General Practitioners	5
Hospital	3
Dr. Gage	1
	60

CHILD GUIDANCE CLINIC

The clinic staff consists of three professional workers, and a change of staff is in consequence a major event. Miss Adamson, the former Psychiatric Social Worker, retired in August, 1962, after having been with the Salford Authority for 17 years. She will be missed, not only by the members of the clinic and other professional workers but also by many parents, some of whom she knew when they themselves were children.

The clinic was fortunate to secure the services of Miss Janus as her successor. She has a great deal of experience, having been the Senior Psychiatric Social Worker in the Manchester Child Guidance Clinic and having worked in one of the neighbouring big mental hospitals. Her appointment means

that training in case work for students of the Manchester University Course for Psychiatric Social Work can continue.

The clinic has continued to struggle with the many requests for help arising from the concern of the referring agencies over delays and waiting lists. One task is to sort out the families which can be helped from those who are more appropriately dealt with by other agencies. Even where help is possible, human nature is such that psychotherapy can achieve a change only very gradually. A difficult child's case is, however, always discussed with teachers and others who are concerned with him.

CLAREMONT OPEN AIR SCHOOL

The school continues to cater for a great variety of handicaps although the majority of children are admitted with chest complaints. There have been between thirty and forty physically handicapped children in school during the year, some of these with severe heart defects. A survey for the Ministry during the year showed about thirty different types of ailment outside the main groupings.

Many very handicapped children have been admitted in the infant age range, and at no time have there been less than nine physically handicapped children in the reception class. There are more cases of mild cerebral palsy than at any time since physically handicapped children were admitted to the school.

The wide range of disability and the ensuing need for many different types of treatment complicated the administration of the school. It is now necessary for physiotherapists to visit in the morning, during the dinner hour, and in the afternoon, in spite of the fact that less severe asthmatics and bronchiectasis cases now receive treatment only two or three times a week. During severe weather many children requiring drainage have had to be treated twice daily. The pattern may be less complicated when physically handicapped children are accommodated at Oaklands.

Dr. R. I. Mackay, Mr. Sayle-Creer and Dr. Scully all hold clinics in the school each term, and the school doctors visit twice weekly. The speech therapist visits once each week, and sunlight treatment is given twice weekly. There are a variety of medicines to be dispensed and all this necessary treatment naturally cuts short the educational day.

Many more children with background difficulties have been received and during the winter it has been more than ever necessary to supplement clothing in many cases. It is often disheartening to find that children given clothing do not always continue to wear it.

School outings have included two day trips to the Lake District, a week-end in Malham for physically handicapped children, and a week in the Lake District during the summer. Our usual party and fancy dress ball were held at Christmas, and forty guests attended. All the children were taken to the circus during the following week.

Swimming classes at Seedley Baths, and special classes for physically handicapped children at Blackfriars Baths, continue to be held. Many certificates were gained and satisfactory progress was made during the year.

Diagnosis	Ages of Children													Total
	4	5	6	7	8	9	10	11	12	13	14	15	16	
Respiratory Infections :														
Asthma	...	1	3	4	8	7	3	4	3	4	1	...	...	38
Bronchiectasis ...	...	1	2	1	2	2	4	1	...	3	3	...	...	19
Bronchitis	...	1	...	3	3	1	3	1	...	...	...	...	...	12
Post Primary Complex	...	2	...	...	...	...	...	...	...	...	...	...	...	2
Other Respiratory Infections	...	1	1	2	9	7	7	1	5	3	...	...	...	36
Physical Handicaps :														
Post Polio	...	...	...	...	...	...	...	1	...	...	1	...	1	3
Muscular Dystrophy	...	...	...	...	...	...	...	...	...	1	...	1	...	2
Spina Bifida	...	1	...	...	...	...	...	...	...	...	...	...	...	1
Cerebral Palsy ...	1	...	...	1	...	2	...	2	...	2	...	...	...	8
Osteogenesis Imperfecta	...	...	...	...	1	...	...	1	...	...	...	...	...	2
Amputation	...	...	...	...	1	...	...	1	...	...	...	...	...	2
Congenital Scoliosis	...	1	...	...	...	...	...	...	...	...	...	...	...	1
Perthes and Pseudocoxalgia ...	...	1	...	1	...	...	...	...	...	...	...	...	...	2
Arthritis, etc.	...	1	...	...	...	...	...	1	...	...	...	...	...	2
T.B. Joints	...	...	...	...	...	...	...	...	...	1	...	...	...	1
Osteomyelitis	...	...	...	...	1	...	...	...	...	...	...	...	...	1
Un-united Fracture	...	...	...	...	...	1	...	...	...	...	...	...	...	1
Biliary Atresia ...	...	1	...	1	...	...	...	...	...	...	...	...	...	2
Severe heart cases ...	1	...	1	...	...	...	...	1	...	...	...	...	...	3
Partially Sighted ...	...	2	1	1	3	3	2	1	...	1	...	...	...	14
Hearts (not so severe)	...	1	1	2	...	...	...	...	1	1	...	...	...	6
Chronic Constipation (mega colon, etc.)	...	...	...	1	...	1	...	1	...	...	...	...	...	3
General Debility ...	...	...	2	2	4	3	4	1	3	...	4	...	...	23
Nervous Debility ...	...	...	...	...	2	...	...	...	...	...	1	...	...	3
Epilepsy	...	...	...	1	...	...	1	...	...	...	1	...	...	3
Testicular Agenesis	...	...	...	...	...	...	...	...	...	...	1	...	...	1
Transplantation Ureters	...	...	...	...	...	...	...	...	1	...	...	...	...	1
Kidney Disease ...	...	...	...	...	2	1	1	...	...	...	...	...	...	4
Anæmia	...	...	...	1	...	2	1	...	...	...	...	...	...	4
Otitis Media	...	...	...	1	...	...	...	...	...	...	...	...	...	1
Duodenal Ulcer ...	...	...	...	...	...	...	1	...	...	...	...	1	...	2
Hernia	...	...	...	...	...	...	...	...	1	...	...	...	...	1
Cœliac Disease ...	...	...	...	1	...	...	...	...	...	...	...	...	...	1

BARR HILL OPEN AIR SCHOOL

During the year ended December, 1962, the school was fortunate to be suitably and adequately staffed without any changes. This has resulted in good progress in the work of the school.

Owing to the imminent closure of the school, admissions have been fewer, especially in September, 1962. Twenty-four children were admitted over the year, chiefly suffering from upper respiratory infections and bronchitis. The average age of the children admitted was eight years four months, and as in the past years the majority were of junior and infant school age, only four

being over eleven years of age. Twenty-three children were discharged as medically fit, the five school leavers amongst them being quickly placed in suitable occupations. The average length of stay was one year eleven months.

It has been possible to restart the classes for children requiring physiotherapy and for those requiring breathing exercises for bronchitis and asthmatic conditions. These classes are held at the Summerville Clinic.

School activities during the year have been a display of English Country Dancing at the Salford Schools' Musical Association Concert, a Parents' Day, visits to Wythenshawe Park and Buile Hill Park, and the usual Christmas Party and Circus Party.

HOPE HOSPITAL SCHOOL

The children's wards have been very busy during the last year, but most of the children have been school-term patients. Owing to improved drugs and treatment, however, the children are usually able to start school work much more quickly after an operation and the teachers on the surgical wards have been dealing with quite large numbers of children "in school." This has been noted, particularly with regard to the children of the nursery age group, as these children seem to be having operations (*e.g.*, for strabismus) at an earlier age.

There is an increasing number of extra-district children.

With the regrouping of the children's wards the open bridges are no longer available, so that there are not the same facilities for teaching out of doors as hitherto and, unfortunately, the poor weather in the summer prevented the children from going into the garden very often.

Of recent months there have been more older children, often from grammar schools, admitted to the adult wards and these have been chiefly orthopædic or psychiatric patients. Because of the size and disposition of the hospital these children prove very time-taking and present a particular difficulty when the teaching staff is depleted owing to sickness or the staggering of holidays.

SPASTIC CLASS

This still remains a very mixed group of children, not only from the point of view of age, but also in the nature of the handicap. The class now includes several children who are only mildly spastic but who present very grave behaviour problems. They require constant and specialised supervision and this is exacting for the teacher and disturbing for the other children. One or two of these children are not really suitable for the class.

In spite of the difficulties the more normal children are making good progress both in formal work and in handicraft and there are now a few quite good readers.

During the last few months the children have lacked speech therapy, and physiotherapy has also been reduced owing to shortage of staff.

HOME TEACHING

There have not been any big changes during the year. The two Home Teachers have continued to visit the children regularly and have found them very eager and appreciative of their lessons. The display of work in September was very attractive, particularly in Art. These children who are taught at home are encouraged to have definite interests and as a result a wide range of subjects is covered by the teachers. M.D. is interested in map-making and architecture. E.G. is very good at needlework. W.S. enjoys nature study, whilst D.M. is a good " all round " worker who will tackle anything he has to do.

PARTIALLY-HEARING CLASS

In September the number on the roll was nine. Of this number, one child attended the clinic for speech therapy. This child is now attending another school.

T.I. has also left the school and is now at Ordsall Secondary School. This boy was in poor health.

The two replacements were both girls—J.M. aged 9 and K.H. aged 5.

J.M. was transferred from Fernhill after Christmas. She has not adapted herself at all well to her new school and would perhaps be better accommodated in an E.S.N. school.

I.W. and J.W. are both severely deaf. They are making good progress in speech and academically.

K.H. is just getting used to the new situation and, although she was very easily upset at first, she is now settling in quite happily.

B.W.'s hearing is considerably improved since an operation on his ear.

B.L. is a happy, healthy little girl. She has a slight hearing deficiency and needs speech training as she has difficulty with consonants. She is making excellent progress.

P.M. is very deaf. His speech is improving and he is making good progress.

P.F. needs to wear a hearing aid to understand speech fully. He is a very slow worker.

D.W. is an intelligent boy.

BROOMEDGE SCHOOL

The average number on roll for the whole year was 47 children, of whom 24 were boys and 23 were girls, an unusually equal division. At midsummer 14 children left the school. All the leavers could read at levels which ranged from a reading age of 5+ to a reading age of 12+.

The following table illustrates the composition of the school in the September Term, 1962.

I.Q.	7+	8+	9+	10+	11+	Totals
40–44	...	...	...	...	1	1
45–49	...	...	...	...	...	...
50–54	...	...	...	...	...	...
55–59	1	1	...	1	...	3
60–64	...	...	...	2	...	2
65–69	1	...	2	2	1	6
70–74	...	...	1	3	...	4
75–79	...	2	8	9	...	19
80–84	...	1	2	4	...	7
85–89	...	...	1	...	...	1
90–94	...	...	...	...	1	1
Totals	2	4	14	21	3	44

Welfare

The average attendance for the year was 89·3 which shows a drop of 1% on previous years. The highest figure was 93·6 for May and the lowest 83 for December.

Physical Health

The routine medical inspection was carried out in four separate minor sessions during the course of the year. Each child was seen once during the course of the year and on a second occasion if the need arose.

In addition to the routine medical examinations all the children of the school, with the exception of one child whose parents refused consent, were vaccinated in February. In March, audiometer tests were administered to all the children. Although varying levels of deafness were detected, no child was deemed to require a hearing aid, nor was it found that any child was seriously handicapped due to a hearing defect.

There was a further increase during the year in the number of children who attend the class for breathing exercises from 12 to 15 children.

Ten children had speech defects of a degree of severity sufficient to warrant recommendation for speech therapy. Despite the discontinuance of the speech clinic in school last year, places were found for the four severest cases. They attend an outside clinic until such time as a new speech therapist is appointed.

FERNHILL SCHOOL

The school is now working at its maximum capacity of 160 children and this number has been decreased only for short periods during the year by nine children moving out of the district, three transfers to approved schools, one to partially deaf class and two children committed to the care of Mental Health. Vacancies as they have occurred have been quickly filled.

As the first batch of children left the school to work it was decided to form an "after-care" club which met weekly for about two months and thereafter each month. This contact has been used by all the school leavers and they have brought to the head teacher and his staff many of their problems with which they meet at this difficult stage.

The following table shows the distribution of children through I.Q. and age ranges at the end of the year. (Ages as at 31st December, 1962).

I.Q.	7	8	9	10	11	12	13	14	15	Totals
40–49	1	2	...	...	...	...	1	1	...	5
50–59	5	...	3	1	2	1	1	2	2	17
60–69	2	1	6	4	6	8	11	1	1	40
70–79	1	3	9	7	14	14	12	10	3	73
80–89	...	1	7	3	6	...	4	1	1	23
Totals	9	7	25	15	28	23	29	15	7	158

This table shows a definite drift towards I.Q's under 80 as compared with last year's figures. On last year's grid there were 40 children with I.Q's over 80. The work done by the conference of officers in E.S.N. education has been of great help in controlling the intake this year and each child was considered individually and his needs assessed by that committee. Most of the children will need to continue at the school for the rest of their school life which would mean that entry to the school will be only at the junior level. This emphasises once again the great need for early ascertainment of children and where there is any doubt whatsoever about a child's progress that child should be referred in order that the reason for his failure may be found out.

SCHOOL MEALS SERVICE

The number of children having dinner at school increased and in October, 1962, was 11,297 compared with 11,137 in the previous year. The number dining represents 48·9% of children present in school, and of this number, some 14·5% have the dinner without payment compared with about 12·5% in the previous year. The percentage of children at school regularly drinking school milk remained at the same level (86%) as the previous year.

Three new canteens were opened during the year.

The service of dinners at school canteens on Saturdays was discontinued in October, 1962, but special provision has been made for undernourished children to have a suitable meal on Saturday at a cafe convenient to their homes.

The programme for replacement of worn out dining room furniture has been accelerated.

STATISTICS

Type of Meal	Served in Maintained Schools		Supplied to Others, *e.g.*, Occupation Centres, Independent Schools		Totals	
	1961-62 *(195 days)	1960-61 *(187 days)	1961-62	1960-61	1961-62	1960-61
Dinners	†2,281,978	†2,150,633	50,928	49,821	2,332,906	2,200,454
Teas	326	524	1 204	759	1 530	1,313

* Excludes holidays and Saturdays.

† Includes dinners served on Saturdays and in school holiday periods :

1960-61—45,760 ; 1961-62—31,094.

PHYSICAL EDUCATION

Most of the problems besetting the Physical Education in the City in 1961 continued in 1962 and it is only in the face of very real difficulties that progress was achieved.

The picture in the secondary schools is brighter than in primary schools. Three more new secondary modern schools have been completed, each with its own fully-equipped gymnasium and changing and showering accommodation. In addition, a fully-equipped gymnasium, also with changing rooms and showers, has been added to one of the existing secondary modern schools, making an addition of four gymnasia complete with ancillary rooms, to the existing sixteen gymnasia in the City.

The opening of the secondary schools has resulted in the reorganisation or partial reorganisation of eight other departments, in most cases making available a hall for indoor physical education lessons in the junior schools. Alterations and improvements to one existing primary school have given a new hall with a good floor and extended playing ground space with a new surface.

The Education Committee continues to supply small apparatus to schools and the marking of school playgrounds is also maintained.

Physical education lessons are part of the curriculum in all types of schools and the changing of clothing for the movement lessons is good, although there are individual exceptions in certain schools.

Staffing remains a major problem. In the secondary modern schools it has been impossible to fill eight specialist posts and for part of the period under review the figure was higher than this so that excellent equipment and opportunities provided by the Education Committee were not fully used. In the primary schools shortage of teachers and unsuitability of staff and the appointment of temporary teachers affects the work adversely.

Organised Games

All schools (except infant departments) include a period of organised games in their time-tables and full use is made of land owned by the Education Committee and the Parks Committee. Football pitches are also rented at the Duncan Mathieson playing field. In the 1961 report it was pointed out that the Education Committee had acquired part of the land which was at one time part of the Duncan Mathieson ground, and this land is now being developed as a playing field area and should later be available for use. There are still insufficient hockey pitches to meet the needs of the girls, but there has been improvement in the condition of the hockey pitches on the Parks Committee land. The position regarding Ordsall Park remains as previously, i.e., the park is open and can be used during school hours but no pitches are marked or equipment available. The opening of the new secondary schools underlines the increasing need for more playing field space and also for additional and much larger games pavilions. This latter applies particularly to the Lower Broughton and Stott Lane playing fields.

The grounds attached to the Light Oaks and Summerville Schools are almost completed and should be ready for use in the ensuing year.

Swimming

Swimming is carried on throughout the year. During the summer bathing period 252 classes were time-tabled for as well as the following classes for the Special Schools :—

Three for educationally subnormal children.
One ,, delicate children.
Two ,, physically handicapped children (one for infants).
One ,, spastics.

The classes were under the supervision of three full-time and three part-time staff.

During the winter months 181 classes were arranged, with one for physically-handicapped children, under the supervision of three full-time staff and two part-time staff.

There has been difficulty in obtaining competent swimming staff and this has resulted in schools scheduled for instruction on the time-table being unable to attend at the baths because there was no-one to teach them. This is reflected by the drop in the number of swimming awards of all types.

In the swimming certificate examinations organised by the Education Committee the following awards were made :—

Third-class certificates	1,241	
Second-class certificates	642	
First-class certificates	388	
Advanced certificates	182	
Total	2,453	awards.

Thanks are due to the Baths Committee for the award of 1,241 season tickets granted to children gaining certificates for the first time.

Royal Life Society examinations continue to be taken by the Salford schoolchildren with the following results :—

Elementary	159	
Intermediate	127	
Bronze Medallion	132	
Bar to Bronze Medallion	43	
Bronze Cross	29	
Scholar Instructor	9	
Unigrip	73	
Total	572	awards.

Mention should be made of the award by the Royal Life Saving Society to Salford of the King Edward VIIth Cup. This award is open to competition throughout Britain and the Commonwealth and is awarded to the organisation making the highest percentage increase in one year over the previous year. Salford obtained a percentage increase of 53·72, the runners-up being the Staffordshire Education Committee with a 37·77 increase. In addition, Salford were also the runners-up for the Primary and Modern Secondary School Award with a percentage increase of 53·57, being beaten by the Ipswich School Swimming Association with 53·76 increase, a difference only of 0·19%.

In the examinations held by the Humane Society for the Hundred of Salford, twelve medals were offered (seven for boys and five for girls) and won by the children in the City.

Out-of-School Activities

A course for basketball has been organised for teachers and also various demonstrations of infant and junior work. Salford Schools Sports Federation again organised a wide range of activities covering swimming, rugby and association football, athletics, cricket, boxing, basketball, netball and rounders. Grateful thanks are due to the teachers who so unstintedly give of their spare time in order to make this possible.

Several schools are taking part in the Duke of Edinburgh Award Scheme and awards have been gained at bronze and silver levels. Some participants are now working for the gold award.

Physical Activity in the Youth Service

A wide number of physical activities have been organised within the youth service and many clubs and youth organisations provide physical activities in Salford. These cover a wide field and include physical education for boys, keep fit for girls, basketball, netball, hockey, boxing, badminton, various types of dancing, table tennis, fives, weight lifting, athletics, swimming, fencing, Judo, football of both codes, rounders, tennis, camping, hiking, club holidays, cycling, cricket, harriers, potholing and archery.

SCHOOL WELFARE

Children and Young Persons Act, 1933-38, Section 18, Employment of Children Byelaws.

During the year 524 applications were received from Salford employers wishing to employ schoolchildren and 480 licences were granted. Thirty-two children declined the invitation to attend the clinic for medical examination and twelve children decided that after all they did not wish to be employed.

The 480 licences issued were for the following employments :—

Delivery of newspapers	460
,, ,, grocery	10
,, ,, meat	7
,, ,, milk	1
Ironmongery (errand boy)	2

All children who are employed are medically examined once every six months and during the year 632 children were examined and found fit to continue their employment. Supervision of the conditions of employment is carried out by officers of the School Welfare Section. During the year School Welfare Officers have made 1,027 enquiries at children's homes or places of employment and made 49 morning or evening patrols. These patrols are made from 6-30 a.m. on weekdays and from 5-30 p.m. on certain Saturdays to ensure that the byelaws are being carried out. As a result of these patrols nine warning letters were sent to parents ; six warning letters were sent to employers ; and one employer was fined £2 on each of two charges of infringement of the byelaws. These patrols also enable the School Welfare Officers to check that the employed children are fully protected against inclement weather, that the legal hours of employment are observed and that no child is expected to perform duties which would cause physical strain.

Children and Young Persons Act, 1933-38, Section 22, Children Employed in Entertainment.

One licence was issued for a girl to appear at a theatre in Manchester during the Christmas season. The girl resided at home and continued to attend her normal school. The Manchester Education Authority made arrangements to ensure that the girl was supervised whilst she was at the theatre.

Clothing and Footwear Cases dealt with in 1962—first application for the Year Only

One thousand four hundred and seventy-two new applications for help with footwear and clothing were received during the year and the applicants have been grouped as follows .—

Parents sick for a long period and in receipt of health insurance benefit	640
Widows and deserted mothers	400

SCHOOL CLINICS

Location of School Clinics.	*Treatment carried out.*
Regent Road	Dental (including Oral Hygiene), Physiotherapy, U.V.R., Chiropody, Audiometry, Minor Ailments, Ear, Nose and Throat, Pædiatric, Orthopædic.
Police Street	Dental, Physiotherapy, U.V.R., Minor Ailments.
Murray Street	Dental, Physiotherapy, U.V.R., Chiropody, Audiometry, Minor Ailments.
Langworthy Centre	Physiotherapy, U.V.R., Chiropody, Audiometry, Minor Ailments.
Kersal Centre	Dental, Physiotherapy, U.V.R., Chiropody, Audiometry.
Encombe Place	Dental (including Orthodontics and Oral Hygiene).
Landseer Street	Physiotherapy.
Summerville Clinic	Physiotherapy.
Cleveland House	Physiotherapy, Speech Therapy.
Ordsall Junior Mixed School	Speech Therapy.
Broughton Secondary Modern School.	Speech Therapy.
Clarendon Secondary Modern School.	Speech Therapy.
Claremont Open-Air School	Physiotherapy, U.V.R., Speech Therapy, Minor Ailments.
Parkfield	Physiotherapy.
Education Office	Ophthalmic.

AVERAGE HEIGHTS AND WEIGHTS, 1962

	Average Age	Average Height	Average Weight	Number Examined
NURSERY				
Boys	4 yrs. 9 mths.	41·7 ins.	39·3 lbs.	237
Girls	4 yrs. 9 mths.	40·6 ins.	37·2 lbs.	211
ENTRANTS				
Boys	5 yrs. 6 mths.	41·3 ins.	41·6 lbs.	1,125
Girls	5 yrs. 6 mths.	42·5 ins.	39·5 lbs.	1,006
LEAVERS				
Boys	13 yrs. 11 mths.	61·2 ins.	102·9 lbs.	808
Girls	14 yrs. 1 mth.	60·6 ins.	105·8 lbs.	587
TOTAL				3,974

STATISTICAL TABLES

PART I.

Medical Inspection of Pupils Attending Maintained and Assisted Primary and Secondary Schools (Including Nursery and Special Schools).

TABLE A—Periodic Medical Inspections.

Age Groups Inspected (by year of birth) (1)	Number of Pupils Inspected (2)	Physical Condition of Pupils Inspected			
		Satisfactory		Unsatisfactory	
		Number (3)	% of Col. 2 (4)	Number (5)	% of Col. 2 (6)
1958 and later	192	191	99·5	1	0·5
1957	1,716	1,668	97·2	48	2·8
1956	766	739	96·5	27	3·5
1955	...	...	...	...	...
1954	...	...	...	...	...
1953	...	...	...	...	...
1952	...	...	...	...	...
1951	...	...	...	...	...
1950	...	...	...	...	...
1949	...	...	...	...	...
1948	...	...	...	...	...
1947 and earlier ...	...	...	...	...	...
				...	...
TOTAL	2,674	2,598	97·2%	76	2·8%

TABLE B—Pupils Found to Require Treatment at Periodic Medical Inspections.
(Excluding Dental Diseases and Infestation with Vermin).

Age Groups Inspected (by year of birth) (1)	For Defective Vision (excluding squint) (2)	For any of the other conditions recorded in Part II (3)	Total Individual Pupils (4)
1958 and later... ...	...	28	28
1957	11	409	416
1956	5	277	282
1955	...	...	...
1954	...	...	...
1953	...	...	...
1952	...	...	...
1951	...	...	...
1950	...	...	...
1949	...	...	...
1948	...	...	...
1947 and earlier ...	...	...	...
	...	...	...
TOTAL	16	714	726

TABLE C—Other Inspections.

Number of special inspections	6,857
Number of re-inspections	4,509
Total	11,366

TABLE D—Infestation with Vermin.

(*a*) Total number of individual examinations of pupils in schools by school nurses or other authorised persons	84,201
b) Total number of individual pupils found to be infested	1,835

PART II.

TABLE A—Return of Defects Found by Medical Inspection in the Year Ended 31st December, 1962.

Defect Code No.	Defect or Disease	Periodic Inspections							
		Entrants		Leavers		Others		Total	
		Requiring Treatment	Requiring Observation	Requiring Treatment	Requiring Observation	Requiring Treatment	Requiring Observation	Requiring Treatment	Requiring Observation
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
4.	Skin.....	50	111	...	...	...	...	50	111
5.	Eyes—								
	(*a*) Vision ...	13	10	...	...	...	...	13	10
	(*b*) Squint ...	83	38	...	...	...	...	83	38
	(*c*) Other ...	24	17	...	...	...	...	24	17
6.	Ears—								
	(*a*) Hearing	20	261	...	...	...	...	20	261
	(*b*) Otitis Media	21	379	...	...	...	...	21	379
	(*c*) Other ...	100	53	...	...	...	...	100	53
7.	Nose and Throat	153	718	...	...	...	...	153	718
8.	Speech.....	22	66	...	...	...	...	22	66
9.	Lymphatic Glands	3	332	...	...	...	...	3	332
10.	Heart	6	79	...	...	...	...	6	79
11.	Lungs	14	127	...	...	...	...	14	127
12.	Developmental—								
	(*a*) Hernia...	9	8	...	...	...	...	9	8
	(*b*) Other ...	7	126	...	...	...	...	7	126
13.	Orthopædic—								
	(*a*) Posture	16	25	...	...	...	...	16	25
	(*b*) Feet.....	140	112	...	...	...	...	140	112
	(*c*) Other ...	65	112	...	...	...	...	65	112
14.	Nervous System—								
	(*a*) Epilepsy	1	7	...	...	...	...	1	7
	(*b*) Other ...	7	139	...	...	...	...	7	139
15.	Psychological—								
	(*a*) Development ...	...	21	...	...	...	...	...	21
	(*b*) Stability	8	174	...	...	...	...	8	174
16.	Abdomen ...	5	21	...	...	...	...	5	21
17.	Other	...	20	...	...	...	...	...	20

PART II.

TABLE B—Special Inspections.

Defect Code No. (1)	Defect or Disease (2)	Special Inspections	
		Requiring treatment (3)	Requiring observation (4)
4.	Skin	405	344
5.	Eyes—		
	(*a*) Vision	292	89
	(*b*) Squint	58	65
	(*c*) Other	51	91
6.	Ears—		
	(*a*) Hearing	56	1,530
	(*b*) Otitis Media	237	387
	(*c*) Other	354	702
7.	Nose and Throat	717	2,287
8.	Speech	70	212
9.	Lymphatic Glands	10	553
10.	Heart	50	282
11.	Lungs	127	640
12.	Developmental—		
	(*a*) Hernia	10	28
	(*b*) Other	32	358
13.	Orthopædic—		
	(*a*) Posture	71	105
	(*b*) Feet	130	191
	(*c*) Other	177	367
14.	Nervous system—		
	(*a*) Epilepsy	38	54
	(*b*) Other	13	341
15.	Psychological—		
	(*a*) Development	26	240
	(*b*) Stability	14	339
16.	Abdomen	8	147
17.	Other	31	477

PART III.

Treatment of Pupils Attending Maintained Primary and Secondary Schools (including Special Schools).

TABLE A—Eye Diseases, Defective Vision and Squint.

	Number of cases known to have been dealt with	
	By the Authority	Otherwise
External and other, excluding errors of refraction and squint	253	—
Errors of refraction (including squint)	2,432	—
Total	2,685	
Number of pupils for whom spectacles were prescribed	2,004	

TABLE B—Diseases and Defects of Ear, Nose and Throat.

	Number of cases known to have been treated	
	By the Authority	Otherwise
Received operative treatment for—		
(*a*) diseases of the ear	—	31
(*b*) adenoids and chronic tonsillitis	—	421
(*c*) other nose and throat conditions	—	42
Received other forms of treatment	—	8
Total		502
Total number of pupils in schools who are known to have been provided with hearing aids—		
(*a*) in 1962	—	9
(*b*) in previous years	—	31

TABLE C—Orthopædic and Postural Defects.

	Number of cases known to have been treated
(*a*) Pupils treated at clinics or out-patient departments	351
(*b*) Pupils treated at school for postural defects	69
Total	420

TABLE D—Diseases of the Skin.

(Excluding uncleanliness for which see Table D of Part I).

	Number of cases known to have been treated
Ringworm—	
(*a*) Scalp	3
(*b*) Body	4
Scabies	3
Impetigo	123
Other skin diseases	1,214
TOTAL	1,347

TABLE E—Child Guidance Treatment.

	Number of cases known to have been treated
Pupils treated at Child Guidance Clinics	103

TABLE F—Speech Therapy.

	Number of cases known to have been treated
Pupils treated by Speech Therapists	113

TABLE G—Other Treatment Given.

	Number of cases known to have been dealt with
(*a*) Pupils with minor ailments	21,839
(*b*) Pupils who received convalescent treatment under School Health Service arrangements	52
(*c*) Pupils who received B.C.G. vaccination	61
(*d*) Other than (*a*), (*b*) and (*c*) above (specify)—	
1. Sun-ray	634
2. Chiropody	1,230
3. Treatment by Pædiatrician	82
TOTAL (*a*)—(*d*)	23,898

PART IV.

Dental Inspection and Treatment Carried Out by the Authority.

(1)	Number of pupils inspected by the Authority's Dental Officers—	
	(*a*) At Periodic Inspections	13,177
	(*b*) As Specials	3,241
	Total (1)	16,418
(2)	Number found to require treatment	10,828
(3)	Number offered treatment	10,828
(4)	Number actually treated	9,435
(5)	Number of attendances made by pupils for treatment, including those recorded at heading 11 (h) below	13,420
(6)	Half days devoted to :	
	(*a*) Periodic (School) Inspection	91
	(*b*) Treatment	1,350
	Total (6)	1,441
(7)	Fillings—	
	(*a*) Permanent Teeth	3,644
	(*b*) Temporary Teeth	548
	Total (7)	4,192
(8)	Number of teeth filled—	
	(*a*) Permanent Teeth	3,527
	(*b*) Temporary Teeth	537
	Total (8)	4,064
(9)	Extractions—	
	(*a*) Permanent Teeth	2,014
	(*b*) Temporary Teeth	5,786
	Total (9)	7,800
(10)	Administration of general anæsthetics for extraction	2,212
(11)	Orthodontics—	
	(*a*) Cases commenced during the year	52
	(*b*) Cases carried forward from previous year	209
	(*c*) Cases completed during the year	51
	(*d*) Cases discontinued during the year	21
	(*e*) Pupils treated with appliances	156
	(*f*) Removable appliances fitted	54
	(*g*) Fixed appliances fitted	12
	(*h*) Total attendances	819
(12)	Number of pupils supplied with artificial teeth	79
(13)	Other operations—	
	(*a*) Permanent Teeth	766
	(*b*) Temporary Teeth	898
	Total (13)	1,664

HANDICAPPED PUPILS

	Blind	Partially Sighted	Deaf	Partially Deaf	Physically Handicapped	Delicate	Maladjusted	E.S.N.	Epileptic	Speech Defects	TOTAL (Cols. 1–10)
During the calendar year ended 31st December, 1962—											
A. How many handicapped pupils were newly assessed as needing special educational treatment at special schools or in boarding homes ? ...	1	4	1	...	12	74	3	81	2	...	178
B. (i) Of the children included at A, how many were newly placed in special schools (other than hospital special schools) or boarding homes ?	...	4	1	...	9	53	1	43	1	...	112
(ii) Of the children assessed prior to 1st January, 1962, how many were newly placed in special schools (other than hospital special schools) or boarding homes ?	...	...	1	...	3	14	...	25	1	...	44
TOTAL (B (i) and B (ii)) ...	...	4	2	...	12	67	1	68	2	...	156

HANDICAPPED PUPILS—*Continued.*

	Blind	Partially Sighted	Deaf	Partially Deaf	Physically Handicapped	Delicate	Maladjusted	E.S.N.	Epileptic	Speech Defects	TOTAL (Cols. 1–10)
On or about 20th January, 1963, how many handicapped pupils from the Authority's area ?—											
C. (i) were requiring places in special schools—TOTAL—											
(*a*) day	...	...	...	...	1	2	...	190	...	...	193
(*b*) boarding	1	...	...	...	1		...	1	...	...	3
(ii) included at (i) had not reached the age of 5 and were awaiting—											
(*a*) day places ...	...	...	...	...	...	...	...	...	...	...	...
(*b*) boarding places	1	...	...	...	1	...	...	...	...	...	2
(iii) included at (i) who had reached the age of 5, but whose parents had refused consent to their admission to a special school, were awaiting—											
(*a*) day places ...	...	...	...	...	...	...	...	60	...	...	60
(*b*) boarding places	...	...	...	...	...	...	...	...	...	...	...
D. (i) were on the registers of (1) maintained special schools as—											
(*a*) day pupils ...	...	12	...	...	37	240	...	202	2	...	493
(*b*) boarding pupils	...	...	...	1	...	...	...	4	...	...	5
(2) non-maintained special schools as—											
(*a*) day pupils ...	...	...	5	...	...	...	...	...	...	...	5
(*b*) boarding pupils	6	...	13	...	6	6	2	13	...	...	46
TOTAL	6	12	18	1	43	246	2	219	2	...	549

HANDICAPPED PUPILS—*Continued.*

	Blind	Partially Sighted	Deaf	Partially Deaf	Physically Handicapped	Delicate	Maladjusted	E.S.N.	Epileptic	Speech Defects	TOTAL (Cols. 1–10)
D (ii) were on the registers of independent schools under arrangements made by the Authority	...	...	...	...	...	...	3	1	...	...	4
TOTAL (D (i) and D (ii)) ...	6	12	18	1	43	246	5	220	2	...	553
(iii) were boarded in homes and not already included under (i) and (ii) above...	...	...	...	...	...	...	1	...	...	...	1
TOTAL (D (i), (ii) and (iii))...	6	12	18	1	43	246	6	220	2	...	554
On or about 20th January, 1963, how many handicapped pupils (irrespective of the area to which they belong) were being educated under arrangements made by the Authority in accordance with Section 56 of the Education Act, 1944 ?—											
E. (i) in hospitals	...	...	...	...	...	...	...	...	...	...	...
(ii) in other groups (*e.g.*, units for spastics, convalescent homes)	...	...	...	...	...	...	...	...	...	...	...
(iii) at home	...	...	...	...	5	1	...	...	...	...	6

CHIROPODY SURVEY SUMMARY, 1962.

Age Group (years)	5 to 6				7 to 8				9 to 10				11 to 12				13 to 15				Total				
Sex	M		F		M		F		M		F		M		F		M		F		M		F		
Defect Group	B	C	B	C	B	C	B	C	B	C	B	C	B	C	B	C	B	C	B	C	B	C	B	C	Total
Corns	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	8	2	10	—	27	2	11	—	35	48
Verruca	—	—	—	—	—	2	—	2	—	—	—	—	—	1	—	6	—	1	—	7	—	4	—	15	19
Weak Long Arch	40	30	38	16	40	19	41	18	53	33	42	21	21	10	86	38	46	15	73	36	200	107	280	129	716
Footwear Degrees of Accuracy in Fitting ...	52	38	50	25	74	28	68	45	66	22	101	26	68	12	230	112	116	44	320	122	376	144	769	330	1,619
Defects of Lesser Toes ...	7	25	7	21	19	13	7	15	5	8	13	5	6	5	29	13	13	7	34	38	50	58	90	92	290
Hallux Valgus	31	10	27	11	30	5	52	4	32	4	70	7	40	2	175	27	62	3	241	42	195	24	565	91	875
Nails	—	—	—	—	1	—	—	—	—	—	1	—	—	1	—	—	1	1	—	—	2	2	1	—	5
Total	130	103	122	73	164	67	168	84	156	68	227	59	135	31	520	204	240	81	668	272	825	350	1,705	692	3,572
Total Number of Children Examined Males and Females	310		269		293		284		313		274		211		581		372		559		1,499		1,967		
Total Number of Males and Females Examined	579				577				587				792				931				3,466				